THURSDAY, MARCH 25, 2010

SEVENTY-THIRD LEGISLATIVE DAY

CALL TO ORDER

The Senate met at 9:00 a.m., and was called to order by Mr. Speaker Ramsey.

PRAYER

The proceedings were opened with prayer by Pastor Bobby Stewart of Redemption Baptist Church/Academy in Lancing, Tennessee, a guest of Senator Yager.

PLEDGE OF ALLEGIANCE

Senator Yager led the Senate in the Pledge of Allegiance to the Flag.

ROLL CALL

The roll call was taken with the following results:

Present 32

Senators present were: Barnes, Berke, Black, Bunch, Burchett, Burks, Crowe, Faulk, Finney, Ford, Gresham, Harper, Haynes, Henry, Herron, Jackson, Johnson, Kelsey, Ketron, Kyle, Marrero, McNally, Norris, Overbey, Southerland, Stewart, Tate, Tracy, Watson, Woodson, Yager and Mr. Speaker Ramsey--32.

COMMUNICATION

March 25, 2010

The Honorable Ron Ramsey
Lieutenant Governor
1 Legislative Plaza
Nashville, Tennessee 37243

Dear Lt. Governor Ramsey:

Please excuse me from attending Session today. I called my office to let them know that I am ill and asked them to prepare a letter to notify you of my inability to be in attendance today.

If you have any questions, please contact Patti Saliba in my office.

Sincerely,

/s/ Mae Beavers

APPROVED: Lieutenant Governor
Ron Ramsey

STANDING COMMITTEE REPORTS

STATE AND LOCAL GOVERNMENT

MR. SPEAKER: Your Committee on State and Local Government begs leave to report that we have carefully considered and recommend for passage: Senate Bills Nos. 2722, 3270 with amendment, 3300, 3361 with amendment, 3404 with amendment, 3489 with amendment, 3545, 3547, 3552 with amendment, 3556, 3590 with amendment, 3606, 3607 with amendments, 3610 with amendment, 3682, 3715 and 3852; and House Joint Resolutions Nos. 746, 763, 823, 884 and 896; also, recommend that Senate Bills Nos. 131 with amendment, 2565 with amendment, 2684, 2810 with amendment, 2908, 3271, 3428 with amendment and 3905 with amendment be referred to Committee on Finance, Ways and Means.

KETRON, Chairperson
March 24, 2010

The Speaker announced that he had referred Senate Bills Nos. 2722, 3270 with amendment, 3300, 3361 with amendment, 3404 with amendment, 3489 with amendment, 3545, 3547, 3552 with amendment, 3556, 3590 with amendment, 3606, 3607 with amendments, 3610 with amendment, 3682, 3715 and 3852; and House Joint Resolutions Nos. 746, 763, 823, 884 and 896 to the Committee on Calendar.

The Speaker announced that he had referred Senate Bills Nos. 131 with amendment, 2565 with amendment, 2684, 2810 with amendment, 2908, 3271, 3428 with amendment and 3905 with amendment to the Committee on Finance, Ways and Means.

EDUCATION

MR. SPEAKER: Your Committee on Education begs leave to report that we have carefully considered and recommend for passage: Senate Bills Nos. 238, 2505 with amendment and 3266.

GRESHAM, Chairperson
March 24, 2010

The Speaker announced that he had referred Senate Bills Nos. 238, 2505 with amendment and 3266 to the Committee on Calendar.

GOVERNMENT OPERATIONS

MR. SPEAKER: Your Committee on Government Operations begs leave to report that we have carefully considered and recommend for passage: Senate Bills Nos. 3181 and 3385; also, recommend that Senate Bills Nos. 3155, 3484 with amendment and 3819 with amendment be referred to Committee on Commerce, Labor and Agriculture; and Senate Bill No. 3151 be referred to Committee on Environment, Conservation and Tourism.

WATSON, Chairperson
March 24, 2010

The Speaker announced that he had referred Senate Bills Nos. 3181 and 3385 to the Committee on Calendar.

The Speaker announced that he had referred Senate Bills Nos. 3155, 3484 with amendment and 3819 with amendment to the Committee on Commerce, Labor and Agriculture.

The Speaker announced that he had referred Senate Bill No. 3151 to the Committee on Environment, Conservation and Tourism.

GENERAL WELFARE, HEALTH AND HUMAN RESOURCES

MR. SPEAKER: Your Committee on General Welfare, Health and Human Resources begs leave to report that we have carefully considered and recommend for passage: Senate Bills Nos. 806 with amendment, 852 with amendment, 2537, 2541 with amendment, 2646 with amendment, 2718, 2797, 2956 with amendment, 3060 with amendment, 3437, 3471 with amendment, 3506 with amendment, 3514 with amendment and 3706; also, recommend that Senate Bills Nos. 2716 with amendment, 2804 with amendment, 3528 with amendment, 3619 with amendment and 3850 with amendment be referred to Committee on Finance, Ways and Means.

CROWE, Chairperson
March 24, 2010

The Speaker announced that he had referred Senate Bills Nos. 806 with amendment, 852 with amendment, 2537, 2541 with amendment, 2646 with amendment, 2718, 2797, 2956 with amendment, 3060 with amendment, 3437, 3471 with amendment, 3506 with amendment, 3514 with amendment and 3706 to the Committee on Calendar.

The Speaker announced that he had referred Senate Bills Nos. 2716 with amendment, 2804 with amendment, 3528 with amendment, 3619 with amendment and 3850 with amendment to the Committee on Finance, Ways and Means.

PRESENTATION

Senator Johnson presented **Senate Joint Resolution No. 813** to Mr. George Hamilton IV.

MOTION

Senator Norris moved, pursuant to Rule 32 and Article II, Section 18 of the Constitution of the State of Tennessee, **Senate Bills Nos. 3937 through 3939** be passed on first consideration, which motion prevailed.

INTRODUCTION OF BILLS

The Speaker announced that the following bills were filed for introduction and passed first consideration:

Senate Bill No. 3937 by Senator Black.
Westmoreland -- As introduced, subject to local approval, changes the name of the "Town of Westmoreland" to the "City of Westmoreland". Amends Chapter 306 of the Private Acts of 1951; as amended.

Senate Bill No. 3938 by Senator Yager.
Roane County -- As introduced, sets salary of county attorney to 60% of the general sessions judges' salary; provides for payment of reasonable travel expenses related to office of county attorney upon showing receipts. Amends Chapter 111 of the Private Acts of 1937; as amended.

Senate Bill No. 3939 by Senator Ketron.
Lewisburg -- As introduced, authorizes reading of ordinance caption on third reading, subject to local approval. Amends Chapter 214 of the Private Acts of 1915; as rewritten.

MOTION

Senator Norris moved, pursuant to Rule 21, **Senate Joint Resolutions Nos. 895 through 902** be passed on first consideration and lie over, which motion prevailed.

INTRODUCTION OF RESOLUTIONS

The Speaker announced that the following resolutions were filed for introduction. Pursuant to Rule 21, the resolutions lie over.

Senate Joint Resolution No. 895 by Senator Burchett.
Memorials, Recognition -- Fiona Hyslop, Scottish Minister for Culture and External Affairs.

Senate Joint Resolution No. 896 by Senator Johnson.
Memorials, Recognition -- Best Buddies.

Senate Joint Resolution No. 897 by Mr. Speaker Ramsey.
General Assembly, Statement of Intent or Position -- Urges Attorney General and Reporter Bob Cooper to join other states in contesting the implementation of any unconstitutional provisions of the federal healthcare legislation.

Senate Joint Resolution No. 898 by Senator Ketron.
Memorials, Death -- Alice Algood.

Senate Joint Resolution No. 899 by Senator Herron.
Highway Signs -- "Roy Bell and David O'Guin Memorial Bridge", State Route 438 in Perry County.

Senate Joint Resolution No. 900 by Senator Watson.
Memorials, Public Service -- Chuck Comer.

Senate Joint Resolution No. 901 by Senator Watson.
Memorials, Public Service -- Thomas Caldwell.

Senate Joint Resolution No. 902 by Mr. Speaker Ramsey.
Memorials, Death -- Alice Algood.

MOTION

Senator Norris moved, pursuant to Rule 21, **Senate Joint Resolutions Nos. 889 through 894** lie over and be referred to the appropriate committees or held on the Clerk's desk, which motion prevailed.

RESOLUTIONS LYING OVER

The Speaker announced that the following resolutions passed second consideration and were referred to the appropriate committees or held on the desk, pursuant to Rule 21:

Senate Joint Resolution No. 889 -- Memorials, Recognition -- A Vintage Affair, 10th anniversary.

The Speaker announced that he had referred Senate Joint Resolution No. 889 to the Committee on Calendar.

Senate Joint Resolution No. 890 -- General Assembly, Statement of Intent or Position -- Need for mammograms for women age 40 and older.

The Speaker announced that he had referred Senate Joint Resolution No. 890 to the Committee on General Welfare, Health and Human Resources.

Senate Joint Resolution No. 891 -- Memorials, Academic Achievement -- Chelsey Crowley, Valedictorian, Oneida High School.

The Speaker announced that he had referred Senate Joint Resolution No. 891 to the Committee on Calendar.

Senate Joint Resolution No. 892 -- Memorials, Academic Achievement -- Shelby Burchfield, Valedictorian, Oneida High School.

The Speaker announced that he had referred Senate Joint Resolution No. 892 to the Committee on Calendar.

Senate Joint Resolution No. 893 -- Memorials, Academic Achievement -- Cody Carson, Salutatorian, Oneida High School.

The Speaker announced that he had referred Senate Joint Resolution No. 893 to the Committee on Calendar.

Senate Joint Resolution No. 894 -- Memorials, Recognition -- Jackson Madison Chapter National Society Daughters of the American Revolution.

The Speaker announced that he had referred Senate Joint Resolution No. 894 to the Committee on Calendar.

RECALL OF BILL

On motion of Senator Watson, **Senate Bill No. 2949** was recalled from the Committee on Calendar.

REFERRAL OF BILL

Senator Watson moved that Senate Bill No. 2949 be rereferred to the Committee on Government Operations, which motion prevailed.

CONSENT CALENDAR NO. 1

Senate Joint Resolution No. 877 -- Memorials, Death -- Thomas H. Hensley.

Senate Joint Resolution No. 878 -- Memorials, Recognition -- Cocke County NJROTC.

Senate Joint Resolution No. 879 -- Memorials, Recognition -- Dan Schlafer.

House Joint Resolution No. 907 -- Memorials, Academic Achievement -- Kathryn Gold, Salutatorian, Marshall County High School.

House Joint Resolution No. 908 -- Memorials, Sports -- Giles County Junior League All-Stars girls softball team.

House Joint Resolution No. 909 -- Memorials, Sports -- Babe Ruth State Champions.

House Joint Resolution No. 910 -- Memorials, Personal Occasion -- Bill and Janice Dean, 50th wedding anniversary.

Senator Faulk moved that all Senate Joint Resolutions be adopted; and all House Joint Resolutions be concurred in, which motion prevailed by the following vote:

Ayes 32
Noes 0

Senators voting aye were: Barnes, Berke, Black, Bunch, Burchett, Burks, Crowe, Faulk, Finney, Ford, Gresham, Harper, Haynes, Henry, Herron, Jackson, Johnson, Kelsey, Ketron, Kyle, Marrero, McNally, Norris, Overbey, Southerland, Stewart, Tate, Tracy, Watson, Woodson, Yager and Mr. Speaker Ramsey--32.

A motion to reconsider was tabled.

CONSENT CALENDAR NO. 2

Senate Bill No. 2531 -- Special License Plates -- As introduced, authorizes issuance of Habitat for Humanity new specialty earmarked plates; allocates 50 percent of proceeds from such plates to Habitat for Humanity of Tennessee. Amends TCA Title 55, Chapter 4.

Senate Bill No. 2782 -- Taxes, Privilege -- As introduced, exempts certain military healthcare officers from $400 professional privilege tax. Amends TCA Title 67, Chapter 4, Part 17.

Senate Bill No. 3140 -- Pensions and Retirement Benefits -- As introduced, authorizes local government entity eligible to participate in the Tennessee consolidated retirement system to elect to participate in any deferred compensation program for state employees, subject to approval of the chair of the retirement system. Amends TCA Title 8, Chapter 25, Parts 1 and 3.

Senate Bill No. 3276 -- Local Education Agency -- As introduced, urges LEAs to consider the needs of working parents in scheduling parent-teacher meetings. Amends TCA Title 49.

Senate Bill No. 3320 -- Education -- As introduced, requires survey of extended learning programs to be disseminated by the Department of Education to all LEAs so that successful programs may be replicated. Amends TCA Title 49, Chapter 2; Title 49, Chapter 3; Title 49, Chapter 6 and Title 49, Chapter 1.

On motion, Senate Bill No. 3320 was made to conform with **House Bill No. 3415**.

On motion, House Bill No. 3415, on same subject, was substituted for Senate Bill No. 3320.

Senate Bill No. 3824 -- State Government -- As introduced, authorizes the board of claims to establish incentive programs for state departments, agencies, and institutions to reduce liabilities to the risk management fund. Amends TCA Section 9-8-108.

Senate Bill No. 3859 -- Private Protective Services -- As introduced, requires automatic revocation of armed or unarmed security guards/officers convicted of certain offenses, if licensee does not request hearing; allows other disciplinary action after hearing. Amends TCA Section 62-35-130.

Senator Faulk moved that all Senate Bills and House Bills be passed on third and final consideration, which motion prevailed by the following vote:

Ayes 32
Noes 0

Senators voting aye were: Barnes, Berke, Black, Bunch, Burchett, Burks, Crowe, Faulk, Finney, Ford, Gresham, Harper, Haynes, Henry, Herron, Jackson, Johnson, Kelsey, Ketron, Kyle, Marrero, McNally, Norris, Overbey, Southerland, Stewart, Tate, Tracy, Watson, Woodson, Yager and Mr. Speaker Ramsey--32.

A motion to reconsider was tabled.

CALENDAR

Senator Kelsey moved that **Senate Joint Resolution No. 763**, as amended, be placed at the heel of the Calendar for today, which motion prevailed.

Senate Bill No. 2497 -- Telecommunications -- As introduced, imposes a statewide prepaid wireless emergency telephone service charge of 2 percent of each retail transaction. Amends TCA Title 7, Chapter 86, Part 1.

Senator Haynes declared Rule 13 on **Senate Bill No. 2497**.

Senator Johnson moved to amend as follows:

AMENDMENT NO. 1

AMEND by deleting all language after the enacting clause and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 7-86-103, is amended by adding the following as new, appropriately designated definitions:

(__) "Prepaid wireless telecommunications service" means a wireless telecommunications service that allows a caller to dial 911 to access the 911 system, which service must be paid for in advance and is sold in predetermined units or dollars of which the number declines with use in a known amount;

(__) "Wireless telecommunications service" means commercial mobile radio service as defined by Section 20.3 of Title 47 of the Code of Federal Regulations, as amended;

SECTION 2. Tennessee Code Annotated, Section 7-86-108(a)(1)(B), is amended by deleting subdivision (iv) and substituting instead the following:

(iv) The service charge shall not be imposed upon customers who pay for service prospectively, known as prepaid wireless telecommunications service customers. Prepaid wireless telecommunications service customers shall be subject to the fee imposed under § 7-86-128.

SECTION 3. Tennessee Code Annotated, Title 7, Chapter 86, Part 1, is amended by adding the following as a new, appropriately designated section:

§ 7-86-128.

(a) As used in this section, unless the context otherwise requires:

(1) "Board" means the emergency communications board established under § 7-86-302;

(2) "Consumer" means a person who purchases prepaid wireless telecommunications service in a retail transaction;

(3) "Department" means the Department of Revenue;

(4) "Prepaid wireless emergency telephone service charge" means the charge that is required to be collected by a seller from a consumer in the amount established under this section;

(5) "Prepaid wireless telecommunications service" means a wireless telecommunications service that allows a caller to dial 911 to access the 911 system, which service must be paid for in advance and is sold in predetermined units or dollars of which the number declines with use in a known amount;

(6) "Provider" means a person that provides prepaid wireless telecommunications service pursuant to a license issued by the Federal Communications Commission;

(7) "Retail transaction" means the purchase of prepaid wireless telecommunications service from a seller for any purpose other than resale, and the purchase of more than one (1) item that provides prepaid wireless telecommunications service, when such items are sold separately, constitutes more than one (1) retail transaction;

(8) "Seller" means a person who sells prepaid wireless telecommunications service to another person; and

(9) "Wireless telecommunications service" means commercial mobile radio service as defined by Section 20.3 of Title 47 of the Code of Federal Regulations, as amended.

(b)(1) There is imposed a statewide prepaid wireless emergency telephone service charge of fifty-three cents (53¢) per each retail transaction or, on and after the effective date of an adjusted amount per retail transaction that is established under subdivision (b)(6), such adjusted amount. However, if a minimal amount of prepaid wireless telecommunications service is sold with a prepaid wireless device for a single, non-itemized price, then the seller may elect not to apply the service charge specified herein to such transaction. For purposes of this paragraph, an amount of service denominated as ten (10) minutes or less, or five dollars ($5) or less, is minimal.

(2) The prepaid wireless emergency telephone service charge shall be collected by the seller from the consumer with respect to each retail transaction occurring in this state. The amount of the prepaid wireless emergency telephone service charge shall be either separately stated on an invoice, receipt, or other similar document that is provided to the consumer by the seller, or otherwise disclosed to the consumer.

(3) For purposes of this subsection (b), a retail transaction that is effected in person by a consumer at a business location of the seller shall be treated as occurring in this state if that business location is in this state, and any other retail transaction shall be treated as occurring in this state if the retail transaction is treated as occurring in this state for purposes of § 67-6-230.

(4) The prepaid wireless emergency telephone service charge is the liability of the consumer and not of the seller or of any provider, except that the seller shall be liable to remit all charges that the seller is deemed to collect where the amount of the charge has not been separately stated on an invoice, receipt, or other similar document provided to the consumer by the seller.

(5) The amount of the prepaid wireless emergency telephone service charge that is collected by a seller from a consumer, if such amount is separately stated on an invoice, receipt, or other similar document provided to the consumer by the seller, shall not be included in the base for measuring any tax, fee, surcharge, or other charge that is imposed by this state, any political subdivision of this state, or any intergovernmental agency.

(6) The prepaid wireless emergency telephone service charge shall be proportionately increased or reduced, as applicable, upon any change to charge imposed under § 7-86-108(a)(1)(B)(i)(*a*). Such increase or reduction shall be effective on the effective date of the change to the charge imposed under § 7-86-108(a)(1)(B)(i)(*a*) or, if later, the first day of the first calendar month to occur at least sixty (60) days after the ratification of an increase by the general assembly. The department shall provide not less than thirty (30) days advance notice of such increase or reduction on the department's Web site.

(c)(1) Prepaid wireless emergency telephone service charges collected by sellers shall be remitted to the department at the times and in the manner provided by Title 67, Chapter 6, with respect to the sales and use taxes. The department shall establish registration and payment procedures that substantially coincide with the registration and payment procedures that apply under Title 67, Chapter 6.

(2) A seller shall be permitted to deduct and retain three percent (3%) of prepaid wireless E911 charges that are collected by the seller from consumers.

(3) The audit and appeal procedures applicable under Title 67, Chapter 1, shall apply to the prepaid wireless emergency telephone service charge.

(4) The department shall establish procedures by which a seller of prepaid wireless telecommunications service may document that a sale is not a retail transaction, which procedures shall substantially coincide with the procedures for documenting sale for resale transactions for sales and use purposes under Title 67, Chapter 6.

(5) The department shall pay all remitted prepaid wireless emergency telephone service charges over to the board within thirty (30) days of receipt, for use by the board in accordance with Part 3 of this chapter. The department may deduct an amount, not to exceed two percent (2%) of collected charges, to be retained by the department to reimburse its direct costs of administering the collection and remittance of prepaid wireless emergency telephone service charges.

(d)(1) A seller that is not a provider shall be entitled to the immunity and liability protections under §§ 7-86-319 and 7-86-320, notwithstanding the requirement in subsection 7-86-320(a) regarding compliance with Federal Communications Commission Order # 05-116.

(2) A provider shall be entitled to the immunity and liability protections under Sections 7-86-319 and 7-86-320.

(3) In addition to the protection from liability provided by subdivisions (d)(1) and (2), each provider and seller shall be entitled to the further protection from liability, if any, that is provided to providers and sellers of wireless telecommunications service that is not prepaid wireless telecommunications service pursuant to §§ 7-86-319 and 7-86-320.

(e) The prepaid wireless emergency telephone service charge imposed by this section shall be the only E911 funding obligation imposed with respect to prepaid wireless telecommunications service in this state, and no tax, fee, surcharge, or other charge shall be imposed by this state, any political subdivision of this state, or any intergovernmental agency, for E911

funding purposes, upon any provider, seller, or consumer with respect to the sale, purchase, use or provision of prepaid wireless telecommunications service.

SECTION 4. This act shall take effect July 1, 2011, the public welfare requiring it.

On motion, Amendment No. 1 was adopted.

Senator McNally moved to amend as follows:

AMENDMENT NO. 2

AMEND by deleting subdivision (b)(1) in § 7-86-128 in Section 3 of the bill as amended by amendment with drafting code # 1485233 and substituting instead the following:

(b)(1)(A) A statewide prepaid wireless emergency telephone charge of fifty-three cents (53¢), or an adjusted amount as provided in subdivision (b)(6), shall be imposed on each retail transaction in lieu of the charge imposed pursuant to § 7-86-108.

(B) Notwithstanding (b)(1)(A), if a minimal amount of prepaid wireless telecommunications service is sold with a prepaid wireless device and a single, non-itemized price is charged for the service, then the seller may elect not to apply the service charge imposed by this subdivision (b)(1). For purposes of this subdivision (B), a minimal amount of service means an amount of service denominated as either ten (10) minutes or less or five dollars ($5.00) or less.

AND FURTHER AMEND by deleting subdivision (b)(6) in § 7-86-128 in Section 3 of the bill as amended by amendment with drafting code # 1485233 and substituting instead the following:

(b)(6)(A) If the emergency telephone service charge imposed under § 7-86-108(a)(1)(B)(i)(*a*) is increased or reduced pursuant to the provisions of such subdivision, then the prepaid wireless emergency telephone charge imposed by subdivision (b)(1) shall be increased or reduced in proportion to such change.

(B) The proportional increase or reduction shall be effective on the first day of the first calendar month to occur at least sixty (60) days after notification is received by the department from the board as provided in § 7-86-108(a)(1)(B)(i)(*b*).

(C) The department shall provide notice on its Web site of an increase or reduction that occurs pursuant to this subdivision (6) at least thirty (30) days before such change takes effect.

AND FURTHER AMEND by adding the following language to precede the last section and renumbering the remaining sections accordingly:

SECTION __. Tennessee Code Annotated, Section 7-86-108(a)(1)(B)(i)(*b*), is amended by deleting the language "shall notify each CMRS provider" in the first sentence of the subdivision and by substituting instead the language "shall notify the Department of Revenue and each CMRS provider".

On motion, Amendment No. 2 was adopted.

Thereupon, **Senate Bill No. 2497**, as amended, passed its third and final consideration by the following vote:

Ayes	24
Noes	5
Present, not voting . . .	1

Senators voting aye were: Barnes, Bunch, Burchett, Burks, Crowe, Faulk, Ford, Gresham, Harper, Haynes, Henry, Johnson, Kelsey, Ketron, McNally, Norris, Overbey, Southerland, Stewart, Tate, Watson, Woodson, Yager and Mr. Speaker Ramsey--24.

Senators voting no were: Berke, Black, Finney, Herron and Marrero--5.

Senator present and not voting was: Jackson--1.

A motion to reconsider was tabled.

Senate Bill No. 2630 -- Education -- As introduced, requires approval by the director of schools, the director's designee, or the local board of education for a teacher to take personal leave on days when professional development, in-service training, or parent-teacher conferences are scheduled. Amends TCA Title 49, Chapter 5, Part 7.

Senator Gresham moved to amend as follows:

AMENDMENT NO. 1

AMEND by deleting all language after the enacting clause and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 49-5-711(c)(1), is amended by deleting the sentence in the subdivision immediately preceding subdivision (A) and by substituting instead the following:

The approval of the director of schools or the director's designee shall be required under the following conditions:

SECTION 2. Tennessee Code Annotated, Section 49-5-711(c)(1), is further amended by deleting the language "; or" at the end of subdivision (B), by substituting instead the punctuation ";" and by adding the following language as new subdivisions (D) and (E):

(D) If personal leave is requested for days scheduled for professional development or in-service training, according to a school calendar adopted by the local board of education prior to the commencement of the school year; or

(E) If personal leave is requested for days scheduled for parent-teacher conferences, according to a school calendar adopted by the local board of education prior to the commencement of the school year.

SECTION 3. This act shall take effect July 1, 2010, the public welfare requiring it.

On motion, Amendment No. 1 was adopted.

Thereupon, **Senate Bill No. 2630**, as amended, passed its third and final consideration by the following vote:

Ayes 23
Noes 9

Senators voting aye were: Berke, Black, Bunch, Burchett, Burks, Crowe, Faulk, Finney, Gresham, Jackson, Johnson, Kelsey, Ketron, McNally, Norris, Overbey, Southerland, Tate, Tracy, Watson, Woodson, Yager and Mr. Speaker Ramsey--23.

Senators voting no were: Barnes, Ford, Harper, Haynes, Henry, Herron, Kyle, Marrero and Stewart--9.

A motion to reconsider was tabled.

Senate Bill No. 2666 -- Highway Signs -- As introduced, provides for erection of directional signs for Historic 1880 Sutton General Store Museum on Interstate 40 at Exit 268 in Putnam County.

Senate Bill No. 2666 passed its third and final consideration by the following vote:

Ayes 32
Noes 0

Senators voting aye were: Barnes, Berke, Black, Bunch, Burchett, Burks, Crowe, Faulk, Finney, Ford, Gresham, Harper, Haynes, Henry, Herron, Jackson, Johnson, Kelsey, Ketron, Kyle, Marrero, McNally, Norris, Overbey, Southerland, Stewart, Tate, Tracy, Watson, Woodson, Yager and Mr. Speaker Ramsey--32.

A motion to reconsider was tabled.

Senator Gresham moved that **Senate Bill No. 2714** be rereferred to the Committee on Calendar, which motion prevailed.

Senate Bill No. 2729 -- Teachers, Principals and School Personnel -- As introduced, requires a teacher evaluation to be available upon request to the teacher. Amends TCA Title 49.

Senator Stewart declared Rule 13 on **Senate Bill No. 2729**.

On motion, Senate Bill No. 2729 was made to conform with **House Bill No. 2810**.

On motion, House Bill No. 2810, on same subject, was substituted for Senate Bill No. 2729.

On motion of Senator Gresham, Amendment No. 1 was withdrawn.

Thereupon, **House Bill No. 2810** passed its third and final consideration by the following vote:

Ayes 32
Noes 0

Senators voting aye were: Barnes, Berke, Black, Bunch, Burchett, Burks, Crowe, Faulk, Finney, Ford, Gresham, Harper, Haynes, Henry, Herron, Jackson, Johnson, Kelsey, Ketron, Kyle, Marrero, McNally, Norris, Overbey, Southerland, Stewart, Tate, Tracy, Watson, Woodson, Yager and Mr. Speaker Ramsey--32.

A motion to reconsider was tabled.

Senator Southerland moved that **Senate Bill No. 2847** be placed on the Calendar for Thursday, April 8, 2010, which motion prevailed.

Senate Bill No. 2780 -- Naming and Designating -- As introduced, names campus at Senator Ben Atchley State Veterans Home in Knox County in honor of Gerald D. Clark.

On motion, Senate Bill No. 2780 was made to conform with **House Bill No. 2868**.

On motion, House Bill No. 2868, on same subject, was substituted for Senate Bill No. 2780.

On motion of Senator Ketron, Amendment No. 1 was withdrawn.

Thereupon, **House Bill No. 2868** passed its third and final consideration by the following vote:

Ayes 32
Noes 0

Senators voting aye were: Barnes, Berke, Black, Bunch, Burchett, Burks, Crowe, Faulk, Finney, Ford, Gresham, Harper, Haynes, Henry, Herron, Jackson, Johnson, Kelsey, Ketron, Kyle, Marrero, McNally, Norris, Overbey, Southerland, Stewart, Tate, Tracy, Watson, Woodson, Yager and Mr. Speaker Ramsey--32.

A motion to reconsider was tabled.

Senate Bill No. 2912 -- Gas, Petroleum Products, Volatile Oils -- As introduced, adds carbon dioxide as a pipeline product that is regulated by the Tennessee regulatory authority. Amends TCA Title 65, Chapter 28, Part 1.

Senator Norris recused himself on **Senate Bill No. 2912**.

Senator Kyle recused himself on **Senate Bill No. 2912**.

Senator Johnson moved to amend as follows:

AMENDMENT NO. 1

AMEND by deleting all language following the enacting clause and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 65-28-109, is amended by inserting the following language after the word "gas" and before the language "subject to the jurisdiction":

, including carbon dioxide transported via interstate pipeline,

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it.

On motion, Amendment No. 1 was adopted.

Senator Gresham moved that **Senate Bill No. 2912**, as amended, be placed on the Calendar for Thursday, April 1, 2010, which motion prevailed.

Senate Bill No. 2943 -- Workers' Compensation -- As introduced, revises determination of meaningful return to work in cases of permanent partial disability by tying it to average weekly wage. Amends TCA Section 50-6-241.

Senator Haynes declared Rule 13 on **Senate Bill No. 2943**.

Senator Berke declared Rule 13 on **Senate Bill No. 2943**.

Senator Overbey declared Rule 13 on **Senate Bill No. 2943**.

Senator Johnson moved to amend as follows:

AMENDMENT NO. 1

AMEND by deleting all language after the enacting clause and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 50-6-241(d)(1)(B)(i), is hereby amended by adding the following language to the end of the subdivision:

Employees who have had a reduction in pay or a reduction in hours due to economic conditions shall not be entitled to reopen their claims under this section if the reduction in pay or reduction in hours affected at least fifty percent (50%) of other hourly employees operating at or out of the same location.

SECTION 2. Tennessee Code Annotated, Section 50-6-241(d)(1)(B)(ii), is hereby amended by adding the following language to the end of the subdivision:

Employees who have had a reduction in pay or a reduction in hours due to economic conditions shall not be entitled to reopen their claims under this section if the reduction in pay or reduction in hours affected at least fifty percent (50%) of other hourly employees operating at or out of the same location.

SECTION 3. This act shall take effect July 1, 2010, the public welfare requiring it, and shall apply to injuries that occur on or after the effective date of this act.

On motion, Amendment No. 1 was adopted.

Thereupon, **Senate Bill No. 2943**, as amended, passed its third and final consideration by the following vote:

Ayes	25
Noes	3

Senators voting aye were: Black, Bunch, Burchett, Burks, Crowe, Faulk, Ford, Gresham, Harper, Haynes, Henry, Herron, Jackson, Johnson, Kelsey, McNally, Norris, Overbey, Southerland, Tate, Tracy, Watson, Woodson, Yager and Mr. Speaker Ramsey--25.

Senators voting no were: Barnes, Berke and Marrero--3.

A motion to reconsider was tabled.

Senate Bill No. 3164 -- Insurance, Health, Accident -- As introduced, revises definition of "medicare supplement policy" to make such policy apply to insurance for persons who do not receive Medicare due to disabilities and who are under age 65. Amends TCA Title 56.

Senator Tracy declared Rule 13 on **Senate Bill No. 3164**.

Senator Stewart declared Rule 13 on **Senate Bill No. 3164**.

Senator Ford declared Rule 13 on **Senate Bill No. 3164**.

Senator Ketron declared Rule 13 on **Senate Bill No. 3164**.

Senator Johnson moved to amend as follows:

AMENDMENT NO. 1

AMEND by deleting all language after the enacting clause and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 56-7-1453, is amended by inserting the following as a new subsection (g):

(g)(1) Insurers offering Medicare supplement policies and certificates in this state to persons sixty-five (65) years of age or older shall also offer Medicare supplement policies to persons in this state who are under sixty-five (65) years of age and eligible for and enrolled in Medicare by reason of disability or end stage renal disease. Except as otherwise provided in this section, all benefits, protections, policies, and procedures that apply to persons sixty-five (65) years of age or older shall also apply to persons that are eligible for and enrolled in Medicare by reason of disability or end stage renal disease.

(2) Individuals who are under sixty-five (65) years of age and eligible for Medicare by reason of disability or end stage renal disease may enroll in a Medicare supplement policy at any time authorized or required by the federal government, or within six (6) months after:

(A) Enrolling in Medicare Part B, or by January 1, 2011, whichever is later;

(B) The date of the notice that such person has been retroactively enrolled in Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration;

(C) No longer having access to alternative forms of health insurance coverage such as accident and sickness policies, employer-sponsored group health coverage or Medicare Advantage plans due to termination or cancellation of such coverage because of the individual's employment status, or an action by a health insurer or employer that is unrelated to the individual's status, conduct or failure to pay premiums; or

(D) Being involuntarily disenrolled from Title XIX (Medicaid) or Title XXI (State Children's Health Insurance Program) of the Social Security Act.

(3) Premium rates for Medicare supplement policies and certificates issued pursuant to this subsection (g) may differ between persons who qualify for Medicare who are sixty-five (65) years of age or older and those who qualify for Medicare by reason of disability or end stage renal disease and who are younger than sixty-five (65) years of age; provided, however, that such differences in premium rates are pursuant to rate schedules that are based on sound actuarial principles and are reasonable in relation to the benefits provided.

SECTION 2. Upon the expiration of five (5) years from the enactment of this act, the Department of Commerce and Insurance shall conduct a study for the purpose of determining the appropriateness of separate premium rating for populations under sixty-five (65) years of age and such study, at a minimum, shall evaluate whether continued separate premium rating is justified in comparison to any negative rating impact or increased cost in premium that would occur to the Medicare supplement insurance population taken as a whole if such separate premium rating were not allowed. The cost of any such study shall be borne by the department within the existing resources of the department at the time of the study.

SECTION 3. For purposes of promulgating rules and regulations, this act shall take effect upon becoming a law, for all other purposes, this act shall take effect on January 1, 2011, the public welfare requiring it.

On motion, Amendment No. 1 was adopted.

Thereupon, **Senate Bill No. 3164**, as amended, passed its third and final consideration by the following vote:

Ayes 30
Noes 0

Senators voting aye were: Barnes, Berke, Black, Bunch, Burchett, Burks, Crowe, Faulk, Ford, Gresham, Harper, Haynes, Henry, Herron, Jackson, Johnson, Kelsey, Ketron, Marrero, McNally, Norris, Overbey, Southerland, Stewart, Tate, Tracy, Watson, Woodson, Yager and Mr. Speaker Ramsey--30.

A motion to reconsider was tabled.

Senate Bill No. 3277 -- Fireworks -- As introduced, removes the present requirement that the law enforcement officials of the county or municipality must also sign the permits for the public fireworks display along with the fire department. Amends TCA Section 68-104-211.

Senator Johnson moved to amend as follows:

AMENDMENT NO. 1

AMEND by deleting Section 1 of the printed bill and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 68-104-211(a)(4), is amended by adding the following language to the end of the subdivision:

All required application-for-permit documents shall be returned to the permittee within three (3) business days from receipt of the application for a permit, unless otherwise agreed by the permittee and applicable officials. Filings required under this part may be submitted in accordance with the provisions for electronic filings as authorized pursuant to § 47-10-118.

On motion, Amendment No. 1 was adopted.

Thereupon, **Senate Bill No. 3277**, as amended, passed its third and final consideration by the following vote:

Ayes 30
Noes 0

Senators voting aye were: Barnes, Berke, Black, Bunch, Burchett, Burks, Crowe, Faulk, Finney, Ford, Gresham, Harper, Haynes, Henry, Herron, Jackson, Johnson, Kelsey, Ketron, Marrero, Norris, Overbey, Southerland, Stewart, Tate, Tracy, Watson, Woodson, Yager and Mr. Speaker Ramsey--30.

A motion to reconsider was tabled.

Senate Bill No. 3399 -- Aircraft and Airports -- As introduced, requires creation of regional airport authority when a majority of the local governments operating a regional airport commission recommend regional airport authority be created. Amends TCA Title 42, Chapter 3, Part 1.

Senator McNally moved to amend as follows:

AMENDMENT NO. 1

AMEND by deleting all language after the enacting clause and by substituting instead the following language:

SECTION 1. Tennessee Code Annotated, Section 42-3-102, is amended by deleting subdivision (8) in its entirety and by substituting instead the following language:

(8) "Governing body" means the official or officials authorized by law to exercise ordinance or other law-making powers of a municipality, county or political subdivision of another state;

SECTION 2. Tennessee Code Annotated, Section 42-3-104(a), is amended by deleting subdivision (3) in its entirety and by substituting instead the following language:

(3) In addition to the procedure set forth in subdivisions (a)(1) and (2), when three (3) or more municipalities and counties and at least one (1) political subdivision of another state jointly create and participate in a regional airport commission and a majority of such municipalities and counties, by resolution of each, recommend the creation of a regional airport authority, and upon each participating municipality and county and political subdivision of another state entering an interlocal agreement pursuant to Title 12, Chapter 9, Part 1, that is approved by the attorney general and reporter before the interlocal agreement takes effect, then each participating municipality, county and political subdivision of another state shall, by resolution of each, create a public body, corporate and politic, to be known as a regional airport authority, which shall be authorized to exercise its functions upon the issuance by the secretary of state of a certificate of incorporation. The governing body of each participating municipality and the governing body of each participating county and the governing body of each political subdivision of another state shall, pursuant to its resolution, appoint the same number of persons as commissioners of the authority as existed in the regional airport commission. Such number of commissioners shall be specified in the certificate of incorporation.

(4)(A) A commissioner or all of the commissioners of an authority may be removed for incompetency, failure or neglect to perform the duties required by law, malfeasance, misfeasance, misconduct or corruption in office or for any other good and sufficient reason.

(B) If the governor makes an appointment pursuant to subdivision (a)(1), (a)(2) or (a)(3), the governor is authorized to remove the commissioner so appointed upon written charges and after a public hearing.

(C) The governing body of the municipality, county, political subdivision of another state or the commissioners of the regional airport authority, as appropriate, that made the original appointment or appointments pursuant to subdivisions (a)(1), (a)(2) or (a)(3) are authorized to remove the commissioner or commissioners so appointed by a two-thirds (2/3) vote of the governing body of the municipality, county, political subdivision of another state or regional airport authority, as appropriate, upon written charges and after a public hearing.

(D) If removed, a vacancy shall exist on the authority of the commissioner or commissioners so removed and the vacancy shall be filled for the unexpired term by the governing body of the municipality, county, political subdivision of another state or the commissioners of the regional airport authority or the governor, as appropriate, in the same manner as in the case of the original appointment.

SECTION 3. This act shall take effect July 1, 2010, the public welfare requiring it.

On motion, Amendment No. 1 was adopted.

Senator Faulk moved that the Senate reconsider its action in adopting Amendment No. 1 to **Senate Bill No. 3399**, which motion prevailed.

On motion, Senate Bill No. 3399 was made to conform with **House Bill No. 3309**.

On motion, House Bill No. 3309, on same subject, was substituted for Senate Bill No. 3399.

Senator McNally renewed his motion to adopt Amendment No. 1, which motion prevailed.

On motion, Amendment No. 1 was adopted.

Thereupon, **House Bill No. 3309**, as amended, passed its third and final consideration by the following vote:

Ayes 31
Noes 0

Senators voting aye were: Barnes, Berke, Black, Bunch, Burchett, Burks, Crowe, Faulk, Finney, Ford, Gresham, Harper, Haynes, Henry, Herron, Jackson, Johnson, Kelsey, Ketron, Kyle, Marrero, McNally, Overbey, Southerland, Stewart, Tate, Tracy, Watson, Woodson, Yager and Mr. Speaker Ramsey--31.

A motion to reconsider was tabled.

Senator Crowe moved that **Senate Bill No. 3416** be placed on the Calendar for Thursday, April 1, 2010, which motion prevailed.

Senate Bill No. 3436 -- Special License Plates -- As introduced, allocates regular portion of funds from Trout Unlimited new specialty earmarked plates to Tennessee Council of Trout Unlimited for distribution to Tennessee chapters, instead of allocating equal amounts to each chapter. Amends TCA Title 55, Chapter 4.

Senate Bill No. 3436 passed its third and final consideration by the following vote:

Ayes 31
Noes 0

Senators voting aye were: Barnes, Berke, Black, Bunch, Burchett, Burks, Crowe, Faulk, Finney, Ford, Gresham, Harper, Haynes, Henry, Herron, Jackson, Johnson, Kelsey, Ketron, Kyle, Marrero, McNally, Overbey, Southerland, Stewart, Tate, Tracy, Watson, Woodson, Yager and Mr. Speaker Ramsey--31.

A motion to reconsider was tabled.

Senate Bill No. 3806 -- Insurance, Health, Accident -- As introduced, enacts the "Tennessee Health Carrier Grievance and External Review Procedure Act". Amends TCA Title 56.

Senator Johnson moved to amend as follows:

AMENDMENT NO. 1

AMEND by deleting all language after the enacting clause and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 56, is amended by adding Section 2 through Section 26 as a newly designated chapter thereto.

SECTION 2. This chapter shall be known and may be cited as the "Tennessee Health Carrier Grievance and External Review Procedure Act". The purpose of this chapter is to provide standards for the establishment and maintenance of procedures by health carriers to assure that covered persons and healthcare providers have the opportunity for the appropriate resolution of grievances, as defined in this chapter.

SECTION 3. For purposes of this chapter, unless the context otherwise requires:

(1) "Adverse determination" means:

(A) A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness and the requested benefit is therefore denied, reduced or terminated, or payment is not provided or made, in whole or in part, for the benefit;

(B) The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier of a covered person's eligibility to participate in the health carrier's health benefit plan; or

(C) Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment for, in whole or in part, a benefit;

(2) "Aggrieved person" means:

(A) A healthcare provider;

(B) A covered person; or

(C) A covered person's authorized representative.

(3) "Authorized representative" means:

(A) A person to whom a covered person has given express written consent to represent the covered person for purposes of this chapter;

(B) A person authorized by law to provide substituted consent for a covered person;

(C) A family member of the covered person or the covered person's treating healthcare professional when the covered person is unable to provide consent;

(D) A healthcare professional when the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the healthcare professional; or

(E) In the case of an urgent care request, a healthcare professional with knowledge of the covered person's medical condition;

(4) "Clinical peer" means a physician or other healthcare professional who holds a non-restricted license in a state of the United States and in the same or similar specialty that would typically manage the medical condition, procedure or treatment under review;

(5) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health carrier to determine the medical necessity and appropriateness of healthcare services;

(6) "Closed plan" means a managed care plan that requires covered persons to use participating providers under the terms of the managed care plan or the plan will not provide covered benefits to the covered person;

(7) "Commissioner" means the Commissioner of Commerce and Insurance;

(8) "Covered benefits" or "benefits" means those healthcare services to which a covered person is entitled under the terms of a health benefit plan;

(9) "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan;

(10) "Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy;

(11) "Emergency services" means healthcare items and services furnished or required to evaluate and treat an emergency medical condition;

(12) "External review organization" means an entity that conducts independent external reviews of adverse determinations and final adverse determinations of a health carrier regarding medical necessity, appropriateness, healthcare setting, level of care or effectiveness of a healthcare service or treatment, or healthcare provider compensation;

(13) "Facility" means an institution licensed under Title 68 providing healthcare services or a healthcare setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation;

(14) "Final adverse determination" means an adverse determination involving a covered benefit that has been upheld by a health carrier at the completion of the health carrier's internal grievance process procedures as set forth in this chapter.

(15) "Grievance" means a written appeal of an adverse determination or final adverse determination submitted by or on behalf of a covered person regarding:

(A) Availability, delivery or quality of healthcare services regarding an adverse determination;

(B) Claims payment, handling or reimbursement for healthcare services;

(C) Matters pertaining to the contractual relationship between a covered person and a health carrier; or

(D) Matters pertaining to the contractual relationship between a healthcare provider and a health carrier;

(16) "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of healthcare services;

(17) "Healthcare professional" means a physician or other healthcare practitioner licensed, accredited or certified to perform specified healthcare services consistent with state law;

(18) "Healthcare provider" or "provider" means a healthcare professional or a facility;

(19) "Healthcare services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease;

(20) "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of healthcare services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or healthcare services;

(21) "Managed care plan" means a health benefit plan that requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use healthcare providers managed, owned, under contract with or employed by the health carrier. "Managed care plan" includes:

(A) A closed plan, as defined in subdivision (6); and

(B) An open plan, as defined in subdivision (26);

(22) "Medical or scientific evidence" means evidence found in the following sources, provided that subdivisions (A) through (B) shall be considered to have more evidentiary value than subdivision (E) and subdivision (E), when considered solely and in the absence of subdivisions (A) through (B), shall not be sufficient to establish medical or scientific evidence for purposes of this chapter:

(A) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(B) Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE);

(C) Medical journals recognized by the Secretary of Health and Human Services under § 1861(t)(2) of the federal Social Security Act, codified in 42 U.S.C.
§ Chapter 7.

(D) The following standard reference compendia:

(i) The American Hospital Formulary Service – Drug Information;

(ii) Drug Facts and Comparisons;

(iii) The American Dental Association Accepted Dental Therapeutics;

(iv) The United States Pharmacopoeia – Drug Information; or

(E) Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

(i) The Federal Agency for Healthcare Research and Quality;

(ii) The National Institutes of Health;

(iii) The National Cancer Institute;

(iv) The National Academy of Sciences;

(v) The Centers for Medicare & Medicaid Services;

(vi) The Federal Food and Drug Administration; and

(vii) Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of healthcare services;

(23) "Medically necessary" or "medical necessity" means healthcare services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

(A) In accordance with generally accepted standards of medical practice;

(B) Clinically appropriate, in terms of type, frequency, extent, site and duration; and considered effective for the patient's illness, injury or disease; and

(C) Not primarily for the convenience of the patient, physician, or other healthcare provider; and

(D) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease;

(24) "NAIC" means the National Association of Insurance Commissioners;

(25) "Network" means the group of participating providers providing services to a managed care plan;

(26) "Open plan" means a managed care plan, other than a closed plan, that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan;

(27) "Participating provider" means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide healthcare services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier;

(28) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the entities listed in this subdivision (28);

(29) "Prospective review" means utilization review conducted prior to an admission or the provision of a healthcare service or a course of treatment in accordance with a health carrier's requirement that the healthcare service or course of treatment, in whole or in part, be approved prior to its provision or admission;

(30) "Register" means the written records kept by a health carrier to document all grievances received during a calendar year;

(31) "Retrospective review" means any review of a request for a benefit that is not a prospective review request. Retrospective review does not include the review of a claim that is limited to veracity of documentation or accuracy of coding; and

(32)(A) "Urgent care request" means a request for a healthcare service or course of treatment with respect to which the time periods for making non-urgent care request determination:

(i) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

(ii) In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the healthcare service or treatment that is the subject of the request;

(B)(i) In determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(ii) Any request that a physician with knowledge of the covered person's medical condition determines is an urgent care request within the meaning of subdivision (32)(A) shall be treated as an urgent care request.

SECTION 4. (a) Except as otherwise specified, this chapter shall apply to all health carriers.

(b) This chapter shall not apply to a policy or certificate that provides:

(1) Coverage only for a specified disease; specified accident or accident-only coverage; credit; dental; disability income; hospital indemnity; long-term care insurance, as defined by § 56-42-103; vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance as defined by the commissioner;

(2) Coverage under a plan through Medicare, Medicaid, or the Federal Employees Health Benefits program (FEHB);

(3) Any coverage issued under 10 U.S.C. § 1072 and any coverage issued as supplement to that coverage;

(4) Any coverage issued as supplemental to liability insurance; workers' compensation or similar insurance; automobile medical-payment insurance or any insurance under which benefits are payable without regard to fault; whether written on a group blanket or individual basis; or

(5) Any plan exempt from regulation under this title due to the Employee Retirement Income Security Act of 1974 (ERISA), compiled in 29 U.S.C. § 1144.

SECTION 5. Nothing in this chapter shall limit or restrict the health carrier from denying coverage on the grounds that the services are determined not to be medically necessary.

SECTION 6. (a) A health carrier shall maintain written records to document all grievances received during a calendar year. The register shall be maintained in a manner that is reasonably clear and accessible to the commissioner.

(b) A request for a first level review of a grievance involving an adverse determination shall be processed in compliance with Section 8 and is required to be included in the health carrier's register.

(c) A request for a second level review of a grievance involving an adverse determination that may be conducted pursuant to Section 9 shall be included in the health carrier's register.

(d) For each grievance, the register shall contain, at a minimum, the following information:

(1) A general description of the reason for the grievance;

(2) The date the grievance was received;

(3) The date of each review or, if applicable, review meeting;

(4) The resolution at each level of the grievance, if applicable;

(5) The date of resolution at each level, if applicable; and

(6) The name of the aggrieved person for whom the grievance was filed.

(e)(1) A health carrier shall retain the register compiled for a calendar year for the shorter of five (5) years or until the commissioner has adopted a final report of an examination that contains a review of the register for such calendar year.

(2)(A) A health carrier shall submit to the commissioner, at least annually, a report in the format specified by the commissioner.

(B) The report shall include for each type of health benefit plan offered by the health carrier:

(i) The number of covered lives that fall under this chapter's protections;

(ii) The total number of grievances;

(iii) The number of grievances for which a covered person and healthcare provider requested a second level voluntary grievance review pursuant to Section 9;

(iv) The number of grievances resolved at each level, if applicable, and their resolution; and

(v) A synopsis of actions being taken to correct problems identified.

SECTION 7. (a) Except as specified in Section 10, a health carrier shall use written procedures for receiving and resolving grievances from aggrieved persons, as provided in Sections 8 and 9, unless otherwise provided by this chapter.

(b) A health carrier shall file with the commissioner a copy of the procedures required under subsection (a), including all forms used to process requests made

pursuant to Sections 8 and 9 of this chapter. Any subsequent material modifications to the documents also shall be filed.

(c) A description of the grievance procedures required under this section shall be set forth in or attached to the membership booklet, provider manual, and health carrier's Web site. The health carrier may include a description of the grievance procedures in the policy, certificate, outline of coverage or other evidence of coverage provided to aggrieved persons.

SECTION 8. (a) Within one-hundred and eighty (180) days after the date of receipt of a notice of an adverse determination, an aggrieved person may file a grievance with the health carrier requesting a first level review of the adverse determination.

(b) The health carrier shall provide the aggrieved person with the name and address of the organizational unit or department designated to coordinate the first level review on behalf of the health carrier.

(c)(1)(A) An aggrieved person does not have the right to attend, or to have a representative in attendance at the first level review; provided, that the aggrieved person is entitled to:

(i) Submit written comments, documents, records and other material relating to the request for benefits for the reviewer or reviewers to consider when conducting the review; and

(ii) Receive from the health carrier, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the covered person's request for benefits.

(B) For purposes of subdivision (c)(1)(A)(ii), a document, record or other information shall be considered relevant to an aggrieved person's request for benefits if the document, record or other information:

(i) Was relied upon in making the benefit determination;

(ii) Was submitted, considered or generated in the course of making the adverse determination, without regard to whether the document, record or other information was relied upon in making the benefit determination;

(iii) Demonstrates that, in making the benefit determination, the health carrier or its designated representatives applied required administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons; or

(iv) Constitutes a statement of policy or guidance with respect to the health benefit plan concerning the denied healthcare service or treatment for the covered person's

diagnosis, without regard to whether the advice or statement was relied upon in making the benefit determination.

(2) The health carrier shall make the provisions of subdivision (c)(1) known to the aggrieved person within five (5) business days after the date of receipt of the grievance; provided, that the request was made to the appropriate organizational unit or department designated by the health carrier.

(d) For purposes of calculating the time periods within which a determination is required to be rendered and notice provided under subsection (e), the time period shall begin on the date the grievance requesting the first level review is filed with the health carrier in accordance with the health carrier's procedures established pursuant to Section 8, without regard to whether all of the information necessary to make the determination accompanies the filing.

(e)(1) A health carrier shall notify and issue a decision, in writing or electronically, to the aggrieved person within the time frames provided in subdivisions (e)(2) and (3).

(2) With respect to a grievance requesting a first level review of an adverse determination involving a prospective review request, the health carrier shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition, but no later than thirty (30) days after the date of the health carrier's receipt of the grievance requesting the first level review made pursuant to subsection (a).

(3) With respect to a grievance requesting a first level review of an adverse determination involving a retrospective review request, the health carrier shall notify and issue a decision within a reasonable period of time, but no later than sixty (60) days after the date of the health carrier's receipt of the grievance requesting the first level review made pursuant to subsection (a).

(f) The decision issued pursuant to subsection (e) shall set forth, in a manner calculated to be understood by the aggrieved person:

(1) The titles and qualifying credentials of the person or persons participating and reviewing in the first level review;

(2) A statement of each reviewer's understanding of the grievance;

(3) Each reviewer's decision in clear terms and the contract basis or medical rationale in sufficient detail for the aggrieved person to respond further to the health carrier's position;

(4) A reference to the evidence or documentation used as the basis for the decision;

(5) For a first level review decision issued pursuant to subsection (e) involving an adverse determination:

(A) The specific reason or reasons for the adverse determination;

(B) A reference to the specific plan provisions on which the determination is based;

(C) A statement that the aggrieved person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as the term "relevant" is defined in subdivision (c)(1)(B), to the covered person's benefit request;

(D) If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person or covered person's authorized representative upon request and the date such policy was effective;

(E) If the adverse determination is based on medical necessity, either an explanation of the criteria for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances, or a statement that an explanation will be provided to the aggrieved person, free of charge upon request; and

(F) If applicable, instructions for requesting:

(i) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as provided in subdivision (f)(5)(D); and

(ii) The written statement of the criteria for the determination, as provided in subdivision (f)(5)(E);

(6) If applicable, a statement indicating:

(A) A description of the process to obtain a second level review of the first level review's decision involving an adverse determination, if the aggrieved person wishes to request a second level review pursuant to Section 9;

(B) The written procedures governing the second level review, including any required time frame for the review; and

(C) A description of the procedures for obtaining an external review of the adverse determination pursuant to this chapter if the aggrieved person decides not to file for a second review of the first level review's decision involving an adverse determination.

SECTION 9. (a) A health carrier shall establish a second level review process to give aggrieved persons, who are dissatisfied with the first level review decision, the option of requesting a second level review.

(b)(1) Health carriers required by this section to establish a second level review process shall provide aggrieved persons with notice pursuant to Section 8, as appropriate, of the option to file a request with the health carrier for a second level review of the first level review's decision rendered pursuant to Section 8.

(2) Upon receipt of a request for a second level review, the health carrier shall send notice within five (5) business days to the covered person or, if applicable, the covered person's authorized representative of the covered person's right to:

(A) Request, within the time frame specified in subdivision (b)(3)(A), the opportunity to appear in person before a review panel of the health carrier's designated representatives;

(B) Receive from the health carrier, upon request, copies of all documents, records and other information that is not confidential or privileged relevant to the aggrieved person's request for benefits;

(C) Present the aggrieved person's case to the review panel;

(D) Submit written comments, documents, records and other material relating to the request for benefits to the review panel for consideration when conducting the second level review both before and, if applicable, during the second level review;

(E) If applicable, ask questions of any representative of the health carrier on the review panel; provided, such questions are governed and relevant to the subject matter of the second level review; and

(F) Be assisted or represented by an individual of the aggrieved person's choice, at the expense of such aggrieved person.

(3)(A) An aggrieved wishing to request to appear in person before the review panel of the health carrier's designated representatives shall make the request to the health carrier within ten (10) business days after the date of receipt of the notice sent in accordance with subdivision (b)(2).

(B) The aggrieved person's right to a fair review shall not be made conditional on the aggrieved person's appearance at the second level review.

(4) Upon receipt of a request for a second level review, the health carrier shall send notice within five (5) business days to the healthcare provider of the healthcare provider's right to:

(A) Receive from the health carrier, upon request, copies of all documents, records and other information that is not confidential or privileged relevant to the aggrieved person's request for benefits;

(B) Submit written comments, documents, records and other material relating to the request for benefits for the review panel to consider when conducting the second level review; and

(C) If applicable, ask questions of any representative of the health carrier on the review panel; provided, such questions are governed and relevant to the subject matter of the second level review.

(c)(1)(A) With respect to a second level review of a first level review decision rendered pursuant to Section 8, a health carrier shall appoint a review panel to review the request.

(B) In conducting the review, the review panel shall take into consideration all comments, documents, records and other information regarding the request for benefits submitted by the aggrieved person pursuant to subdivision (b)(2), without regard to whether the information was submitted or considered in reaching the first level review's decision.

(C) The review panel shall have the legal authority to bind the health carrier to the review panel's decision.

(2)(A) Except as provided in subdivision (c)(2)(B), a majority of the review panel shall be comprised of individuals who were not involved in the first level review decision rendered pursuant to Section 8.

(B) An individual who was involved with the first level review decision may be a member of the review panel or appear before the review panel to present information or answer questions.

(C) The health carrier shall ensure that the individuals conducting the second level review of the first level review decision have appropriate expertise or have access to appropriate expertise that consists of similar knowledge and training or specialty that typically is involved in managing the medical condition, procedure or treatment that is the subject of the grievance under second level review.

(D) No member of the review panel shall have a direct financial interest in the outcome of the second level review.

(d) The procedures for conducting the second level review shall include the provisions described in subdivisions (1) through (5):

(1) The review panel shall schedule and hold the second level review within sixty (60) business days after the date of receipt of the request for a second level review.

(A) The aggrieved person shall be notified in writing at least fifteen (15) business days in advance of the date of the second level review.

(B) The health carrier shall not unreasonably deny a request for postponement of the second level review made by the aggrieved person.

(2) The second level review shall be held during regular business hours at a location that meets the guidelines established by the Americans with Disabilities Act, compiled in 42 U.S.C. § 1201, et seq., to the aggrieved person;

(3) In cases where an in-person second level review is not practical for geographic reasons, or any other reason, a health carrier shall offer the aggrieved person the opportunity to communicate with the review panel, at the health carrier's sole expense, by conference call or other appropriate technology as determined by the health carrier;

(4) The review panel shall provide the aggrieved person notice of the right to have an attorney present at the second level review; and

(5) The review panel shall issue a written or electronic decision, as provided in subsection (e), to the aggrieved person within five (5) business days of completing the second level review meeting.

(e) A decision issued pursuant to this section shall include the:

(1) Titles and qualifying credentials of the reviewers on the review panel;

(2) Statement of the review panel's understanding of the nature of the grievance and all pertinent facts;

(3) Rationale for the review panel's decision;

(4) Reference to evidence or documentation considered by the review panel in rendering its decision; and

(5) In cases concerning a grievance involving an adverse determination:

(A) Instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; and

(B) If applicable, a statement describing the procedures for obtaining an external review of the adverse determination pursuant to this chapter.

SECTION 10. (a) A health carrier shall establish written procedures for the expedited review of urgent care requests of grievances involving an adverse determination.

(b) In addition to subsection (a), a health carrier shall provide expedited review of a grievance involving an adverse determination with respect to concurrent review of urgent care requests involving an admission, availability of care, continued stay or

healthcare service for a covered person who has received emergency services, but has not been discharged from a facility.

(c) The procedures shall allow an aggrieved person to request an expedited review under this section orally, in writing or electronically.

(d) A health carrier shall appoint an appropriate clinical peer, or peers as would typically manage the case being reviewed, to review the adverse determination. The clinical peer or peers shall not have been involved in rendering the initial adverse determination.

(e) In an expedited review, the health carrier shall provide or transmit all necessary documents and information considered when making the adverse determination to the aggrieved person participating in the expedited review process electronically or by telephone, facsimile or any other expeditious method available.

(f)(1) An expedited review decision shall be rendered and the aggrieved person shall be notified of the decision in accordance with subsection (h) as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two (72) hours after the receipt of the request for the expedited review.

(2) If the expedited review is of a grievance involving an adverse determination with respect to a concurrent review of an urgent care request, the service shall be continued until the covered person has been notified of the determination or until the aggrieved person determines that the urgent care is no longer appropriate or necessary.

(g) For purposes of calculating the time periods within which a decision is required to be rendered under subsection (f), the time period within which the decision is required to be rendered shall begin on the date that the request is filed with the health carrier in accordance with the health carrier's procedures established pursuant to Section 8; without regard to whether all the information necessary to make the determination accompanies the filing.

(h)(1) A notification of a decision under this section shall, in a manner calculated to be understood by the aggrieved person, set forth:

(A) The titles and qualifying credentials of the person or persons participating in the expedited review process;

(B) A statement of the reviewers' understanding of the grievance;

(C) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the aggrieved person to respond further to the health carrier's position;

(D) A reference to the evidence or documentation used as the basis for the decision; and

(E) If the decision involves an adverse determination, the notice shall provide:

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;

(iv) If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion, effective at the time of service, to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the aggrieved person upon request;

(v) If the adverse determination is based on medical necessity, an explanation of the criteria for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the aggrieved person free of charge upon request;

(vi) If applicable, instructions for requesting:

(a) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination in accordance with subdivision (h)(1)(E)(iv); or

(b) The written statement of the criteria for the adverse determination in accordance with subdivision (h)(1)(E)(v); and

(vii) A statement describing the procedures for obtaining an external review of the adverse determination pursuant to this chapter.

(2)(A) A health carrier may provide the notice required under this section orally, in writing or electronically.

(B) If notice of the adverse determination is provided orally, the health carrier shall provide written or electronic notice of the adverse determination within three (3) days following such oral notification.

SECTION 11. The commissioner may, after notice and hearing, promulgate reasonable rules and regulations to carry out the provisions of this chapter. Such rules and regulations shall be subject to review in accordance with the Uniform Administrative Procedures Act, compiled in Title 4, Chapter 5.

SECTION 12. A person that violates this chapter shall be subject to the penalties set forth in § 56-2-305.

SECTION 13. (a) For purposes of this section, "approved entity" means:

(1) URAC; or

(2) Other nationally recognized private accrediting entity employing standards for the accreditation of external review programs that the commissioner deems are substantially equivalent to the standards for conducting an external review pursuant to Sections 14 through 19 of this chapter.

(b) A health carrier may elect, in writing to the commissioner, to conduct its external review program in accordance with:

(1) Sections 14 through 19 of this chapter; or

(2) The external review program of an approved entity, provided that the health carrier receives and maintains accreditation from the approved entity. Sections 21 and 22 of this chapter shall not apply to a health carrier that receives and maintains accreditation from the approved entity.

(c) The commissioner may evaluate the external review procedures of an approved entity. If after a hearing is conducted in accordance with the Uniform Administrative Procedures Act, compiled in Title 4, Chapter 5, Part 3, the commissioner finds that an approved entity has amended its external review procedures to the extent that such procedures are no longer consistent with the purposes of this chapter, the commissioner shall issue a written order specifying in what respects those procedures are inconsistent.

(d) A health carrier that has elected to conduct its external review program in accordance with the standards of an approved entity, that is the subject of the commissioner's order issued pursuant to subsection (c), shall have sixty (60) days from the effective date of the commissioner's order to:

(1) Elect, in writing, to utilize another external review program under subsection (b); or

(2) Demonstrate to the commissioner's satisfaction that the approved entity has subsequently amended its procedures so that such procedures are consistent with the purposes of this chapter.

SECTION 14. (a) A health carrier shall notify the aggrieved person in writing of the right to request an external review to be conducted pursuant to Sections 17 and 19 of this chapter and include the appropriate statements and information set forth in

subsection (b) of this section at the same time that the health carrier sends written notice of a final adverse determination. As part of the written notice required under this subsection (a), a health carrier shall include the following, or substantially equivalent language:

We have denied your request for the provision of or payment for a healthcare service or course of treatment. You have the right to have our decision reviewed by healthcare professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, healthcare setting, level of care or effectiveness of the healthcare service or treatment you requested by submitting a written request for external review to us.

(b) The health carrier shall include the following in the notice required under subsection (a):

(1) For a notice related to an adverse determination, a statement informing the aggrieved person that:

(A) If the covered person has a medical condition where the timeframe for completion of an expedited review of a grievance involving an adverse determination set forth in Section 10 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the aggrieved person may file a request for an expedited external review to be conducted pursuant to Section 18.

(B) The aggrieved person may file a grievance under the health carrier's internal grievance process as set forth in Section 8. An aggrieved person shall be considered to have exhausted the health carrier's internal grievance process for purposes of this section, if the aggrieved person:

(i) Has filed a grievance involving an adverse determination pursuant to Section 8; and

(ii) Has not received a written decision on the grievance from the health carrier within thirty (30) days for prospective review determinations and sixty (60) days for retrospective review determinations following the date the aggrieved person filed the grievance with the health carrier unless the aggrieved person requested or agreed to a delay.

(2) For a notice related to a final adverse determination, a statement informing the aggrieved person that:

(A) If the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to Section 17 or Section 19 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the aggrieved person may file a request for an expedited external review pursuant to Section 18 or Section 19(n).

(B) If the final adverse determination concerns an admission, availability of care, continued stay or healthcare service for which the covered person received emergency services, but has not been discharged from a facility, the aggrieved person may file a request for an expedited external review pursuant to Section 18 or Section 19(n).

(c) In addition to the information to be provided pursuant to subdivision (b)(1), the health carrier shall include a copy of the description of both the standard and expedited external review procedures highlighting the provisions in the external review procedures that give the aggrieved person the opportunity to submit additional information and any forms used to process an external review.

(d) As part of any forms provided under subdivision (b)(2), the health carrier shall include an authorization form that complies with the requirements of 45 C.F.R. § 164.508, by which the covered person, for purposes of conducting an external review under this chapter, authorizes the health carrier and the covered person's treating healthcare provider to disclose protected health information, including, but not limited to, medical records concerning the covered person that are pertinent to the external review.

SECTION 15. (a) Except for a request for an expedited external review as set forth in Section 18 or 19(n), all requests for external review shall be made in writing to the health carrier.

(b) Unless otherwise set forth by this chapter, an aggrieved person may file a request for external review after the receipt of a final adverse determination.

SECTION 16. (a) Except as provided in subsection (b), a request for an external review pursuant to Section 17 or Section 19 shall not be made until the aggrieved person has exhausted the health carrier's internal grievance process as set forth in this chapter.

(1) An aggrieved person shall be considered to have exhausted the health carrier's internal grievance process for purposes of this section, if the aggrieved person:

(A) Has filed a grievance involving an adverse determination pursuant to Section 8; and

(B) Has not received a written decision on the grievance from the health carrier within thirty (30) days for prospective review determinations and sixty (60) days for retrospective review determinations following the date that the aggrieved person filed the grievance with the health carrier unless the aggrieved person requested or agreed to a delay.

(2) Notwithstanding subdivision (a)(1)(B), an aggrieved person may not file a request for an external review of an adverse determination involving a retrospective review determination until the covered person has exhausted the health carrier's internal grievance process.

(b) A request for an external review of an adverse determination may be filed before the covered person has exhausted the heath carrier's internal grievance procedures, as set forth in Section 8, whenever the health carrier agrees to waive the exhaustion requirement.

(c) If the requirement to exhaust the health carrier's internal grievance procedures is waived pursuant to subsection (b), the aggrieved person may file a request in writing for a standard external review as set forth in Section 17 or Section 19.

SECTION 17. (a) Within six (6) months after the date of receipt of a notice of an adverse determination or final adverse determination pursuant to Section 14, an aggrieved person may file a request for an external review with the health carrier.

(b) Within ten (10) business days following the date of receipt of the copy of the external review request, the health carrier shall complete a preliminary review of the request to determine whether:

(1) The individual is or was a covered person in the health benefit plan at the time that the healthcare service was requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time that the healthcare service was provided;

(2) The healthcare service that is the subject of the adverse determination or the final adverse determination is a covered service under the covered person's health benefit plan;

(3) The covered person has exhausted the health carrier's internal grievance process as set forth in this chapter unless the covered person is not required to exhaust the health carrier's internal grievance process pursuant to Section 16; and

(4) The covered person has provided all the information and forms required to process an external review, including the release form provided pursuant to Section 14.

(c) Within three (3) business days after completion of the preliminary review, the health carrier shall notify the aggrieved person in writing whether:

(1) The request is complete; and

(2) The request is eligible for external review.

(d) If the request set out in subsection (a):

(1) Is not complete, the health carrier shall notify the aggrieved person in writing and include in the notice what information or materials are needed to make the request complete; or

(2) Is not eligible for external review, the health carrier shall notify the aggrieved person in writing and include in the notice the reasons for its ineligibility.

(e) The notice of initial determination shall include a statement informing the aggrieved person that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the commissioner.

(f) The commissioner may determine that a request is eligible for external review under this chapter notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(1) In making a determination under this subdivision (f), the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this chapter.

(2) Whenever the health carrier or commissioner determines that a request is eligible for external review following the preliminary review conducted pursuant to subdivision (c)(2), within three (3) business days after the determination by the health carrier or within three (3) business days after the date of receipt of the determination by the commissioner, the health carrier shall notify the aggrieved person in writing of the request's eligibility and acceptance for external review.

(g) The health carrier shall include in the notice provided to the aggrieved person, a statement that additional information may be submitted in writing to the health carrier within six (6) business days following the date of receipt of the notice provided pursuant to subdivision (f)(2), and that the external review organization shall consider such additional information when conducting the external review. The health carrier is not required to, but may, accept and consider such additional information submitted by the aggrieved person after six (6) business days.

(h) Within six (6) business days after the date of receipt of the notice provided pursuant to subsection (g), the health carrier shall provide to the external review organization any documents and information considered in making the adverse determination or final adverse determination.

(1) Failure by the health carrier to provide the documents and information within the time specified in subsection (h) shall not delay the external review.

(2) If the health carrier fails to provide the documents and information within the time specified in subsection (h), the external review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(3) The external review organization shall notify the health carrier within one (1) business day of its decision to reverse the adverse determination or final adverse determination pursuant to subdivision (h)(2). The health carrier shall notify the aggrieved person within three (3) business days of the external review organization's decision.

(i) The external review organization shall review all of the information and documents received pursuant to subsection (g) and any other information submitted in writing by the aggrieved person.

(j) Upon receipt of the information required to be forwarded pursuant to subsection (g), the health carrier may reconsider its final adverse determination that is the subject of the external review.

(1) Reconsideration by the health carrier of its final adverse determination shall not delay or terminate the external review.

(2) The external review may only be terminated by the health carrier if the health carrier decides, upon completion of its reconsideration, to reverse its final adverse determination and provide coverage or payment for the healthcare service that is the subject of the adverse determination or final adverse determination. If the health carrier reverses its previous determinations pursuant to this subsection (j), the health carrier shall not at a later date reverse its reversal.

(3) Within three (3) business days after making the decision to reverse its adverse determination or final adverse determination, the health carrier shall notify the aggrieved person and the external review organization in writing of its decision. The external review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subdivision (l)(3).

(k) In addition to the documents and information provided pursuant to subsections (g) and (h), the external review organization, to the extent that the information or documents are available and the external review organization considers them appropriate, shall consider the following in reaching a decision:

(1) The covered person's pertinent medical records;

(2) The attending healthcare professional's recommendation;

(3) The consulting reports from appropriate healthcare professionals and other documents submitted by the aggrieved person or the covered person's treating physician or healthcare professional;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the external review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

(5) Any applicable clinical review criteria developed and used by the health carrier;

(6) The most appropriate practice guidelines, which shall include applicable medical or scientific evidence-based standards;

(7) Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

(A) The Agency for Healthcare Research and Quality;

(B) The National Institutes of Health;

(C) The National Cancer Institute;

(D) The National Academy of Sciences;

(E) The Centers for Medicare & Medicaid Services;

(F) The Federal Food and Drug Administration; and

(G) Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of healthcare services; and

(8) The opinion of the external review organization's clinical reviewer or reviewers after considering subdivisions (1)-(7), to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

(l) In reaching a decision, the external review organization is not bound by any decisions or conclusions reached during the health carrier's internal grievance process as set forth in this chapter. However, the external review organization shall be bound by the terms and conditions of the covered person's health benefit plan.

(m) Within forty-five (45) days after the date of receipt of the request for an external review, the external review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to the health carrier.

(n) Within one (1) business day after rendering the decision under subsection (m), the external review organization shall notify the health carrier. Within three (3) business days after receiving the decision from the external review organization, the health carrier shall notify the aggrieved person of the external review organization's decision to uphold or reverse the adverse determination or final adverse determination. If the decision involved healthcare provider compensation, the health carrier shall make appropriate payment to the healthcare provider within ten (10) business days of the receipt of a notice of the external review organization's decision.

(o) The external review organization shall include in the notice sent pursuant to subsection (m):

(1) A general description of the reason for the request for external review;

(2) The date that the external review organization received the assignment from the health carrier to conduct the external review;

(3) The date that the external review was conducted;

(4) The date of the external review organization's decision;

(5) The principal reason or reasons for the external review organization's decision, including any applicable, medical or scientific evidence-based standards used as a basis for its decision;

(6) The rationale for the external review organization's decision; and

(7) References to the evidence or documentation, including the medical or scientific evidence-based standards, considered in reaching the external review organization's decision.

(p) Upon receipt of a notice of a decision pursuant to subsection (m) reversing the adverse determination or final adverse determination, the health carrier shall immediately approve the coverage that was the subject of the adverse determination or final adverse determination. If the decision involved healthcare provider compensation, the health carrier shall make appropriate payment to the healthcare provider within ten (10) business days of the receipt of a notice of the external review organization's decision.

(q) The health carrier, regardless of URAC accreditation, shall have a contract with at least two (2) or more external review entities and may give the aggrieved person the opportunity to select, from among the external review organizations that the health carrier has contracts with, the external review organization to conduct the review.

SECTION 18. (a) Except as provided in subsection (f), an aggrieved person may make a request for an expedited external review with the health carrier at the time the aggrieved person receives:

(1) An adverse determination if:

(A) The adverse determination involves a medical condition of the covered person for which the timeframe for completion of an expedited internal review of a grievance involving an adverse determination set forth in Section 10 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and

(B) The aggrieved person has filed a request for an expedited review of a grievance involving an adverse determination as set forth in Section 10; or

(2) A final adverse determination:

(A) If the covered person has a medical condition where the timeframe for completion of a standard external review pursuant to Section 17 would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; or

(B) If the final adverse determination concerns an admission, availability of care, continued stay or healthcare service for which the covered person received emergency services, but has not been discharged from a facility.

(b)(1) Immediately upon receipt of the request, the health carrier shall determine whether the request meets the reviewability requirements set forth in Section 17. The health carrier shall immediately notify the aggrieved person of its eligibility determination regarding the availability of external review.

(2) The notice of initial determination shall include a statement informing the aggrieved person that a health carrier's initial determination that an external review request is ineligible for review and that the aggrieved person may file a complaint with the commissioner.

(A) The commissioner may determine that a request is eligible for external review notwithstanding a health carrier's initial determination that the request is ineligible and that it be referred to external review.

(B) In making a determination under (A), the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this chapter.

(c) Upon making a determination that a request is eligible for expedited external review the health carrier shall immediately notify the aggrieved person in writing that the request is eligible for external review.

(d) At the same time, the health carrier shall immediately notify the external review organization and provide or transmit all necessary documents and information considered when making the adverse determination or final adverse determination electronically or by telephone, facsimile or any other expeditious method available.

(e) In addition to the documents and information provided or transmitted pursuant to subsection (d), the external review organization, to the extent that the information or documents are available and the external review organization considers them appropriate, shall consider the following in reaching a decision:

(1) The covered person's pertinent medical records;

(2) The attending healthcare professional's recommendation;

(3) Consulting reports from appropriate healthcare professionals and other documents submitted by the health carrier, covered person, the covered person's authorized representative or the covered person's treating provider;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that the external review organization's decision is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier;

(5) The most appropriate practice guidelines, which shall include medical or scientific evidence-based standards;

(6) Applicable clinical review criteria developed and used by the health carrier in making adverse determinations; and

(7) Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including:

(A) The Federal Agency for Healthcare Research and Quality;

(B) The National Institutes of Health;

(C) The National Cancer Institute;

(D) The National Academy of Sciences;

(E) The Centers for Medicare & Medicaid Services;

(F) The Federal Food and Drug Administration; and

(G) Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of healthcare services; and

(8) The opinion of the external review organization's clinical reviewer or reviewers after considering subdivisions (e)(1)-(7) to the extent that the information and documents are available and the clinical reviewer or reviewers consider appropriate.

(f) As expeditiously as the covered person's medical condition or circumstances requires, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review that meets the reviewability requirements, the external review organization shall make a decision to uphold or reverse the adverse determination or final adverse determination; and

(1) Notify the health carrier of the decision and the health carrier must immediately notify the aggrieved person of the external review organization's decision. The aggrieved person must receive the decision of the expedited external review within seventy-two (72) hours after the date of receipt of the request for expedited external review.

(2)(A) If the notice provided pursuant to subsection (f) was not in writing, within forty-eight (48) hours after the date of providing such notice, the external review organization shall provide written confirmation of the decision to the health carrier; and include the information set forth in Section 18.

(B) The health carrier shall immediately notify the aggrieved person of the external review organization's decision and include the information set forth in Section 18.

(C) Upon receipt of notice of the decision rendered pursuant to subdivision (f)(1) reversing the adverse determination or final adverse determination, the health carrier shall immediately approve the coverage that was the subject of the adverse determination or the final adverse determination.

(g) An expedited external review shall not be provided for retrospective adverse or final adverse determinations.

SECTION 19. (a) Within six (6) months after the date of receipt of a notice of an adverse determination or final adverse determination that involves a denial of coverage based on a determination that the healthcare service or treatment recommended or requested is investigational an aggrieved person may file a request for external review with the health carrier.

(b) Within ten (10) business days following the date of receipt of the copy of the external review request, the health carrier shall conduct and complete a preliminary review of the request to determine whether:

(1) The individual is or was a covered person in the health benefit plan at the time that the healthcare service or treatment was recommended or requested or, in the case of a retrospective review, was a covered person in the health benefit plan at the time that the healthcare service or treatment was provided;

(2) The recommended or requested healthcare service or treatment that is the subject of the adverse determination or final adverse determination:

(A) Is a covered benefit under the covered person's health benefit plan except for the health carrier's determination that the service or treatment is experimental or investigational for a particular medical condition; and

(B) Is not explicitly listed as an excluded benefit under the covered person's health benefit plan with the health carrier;

(3) The covered person's treating physician has certified that one (1) of the following situations is applicable:

(A) Standard healthcare services or treatments have not been effective in improving the condition of the covered person;

(B) Standard healthcare services or treatments are not medically appropriate for the covered person; or

(C) There is no available standard healthcare service or treatment covered by the health carrier that is more beneficial than the recommended or requested healthcare service; or

(4) The covered person's treating physician:

(A) Has recommended a healthcare service or treatment that the physician certifies, in writing, is likely to be more beneficial to the covered person, in the physician's opinion, than any available standard healthcare services or treatments; or

(B) Who is a licensed, board-certified or board-eligible physician qualified to practice in the area of medicine appropriate to treat the covered person's condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the healthcare service or treatment requested by the covered person that is the subject of the adverse determination or final adverse determination is likely to be more beneficial to the covered person than any available standard healthcare services or treatments;

(5) The aggrieved person has exhausted the health carrier's internal grievance process as set forth in this chapter unless the aggrieved person is not required to exhaust the health carrier's internal grievance process pursuant to Section 16; and

(6) The aggrieved person has provided all the information and forms that are necessary to process an external review, including the release form provided under Section 14.

(c) Within three (3) business days after completion of the preliminary review, the health carrier shall notify the aggrieved person in writing whether:

(1) The request is complete; and

(2) The request is eligible for external review.

(d) If the request set out in subsection (a):

(1) Is not complete, the health carrier shall notify the aggrieved person, in writing, and include in the notice what information or materials are needed to make the request complete; or

(2) Is not eligible for external review, the health carrier shall notify the aggrieved person in writing and include in the notice the reasons for its ineligibility.

(e) The notice of initial determination shall include a statement informing the aggrieved person that a health carrier's initial determination that the external review request is ineligible for review may be appealed to the commissioner.

(f)(1) The commissioner may determine that a request is eligible for external review under this chapter notwithstanding a health carrier's initial determination that the request is ineligible and require that it be referred for external review.

(2) In making a determination under this subsection, the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this chapter.

(g)(1) Whenever the health carrier or commissioner determines that a request is eligible for external review following the preliminary review conducted pursuant to subdivision (c)(2), within three (3) business days after the

determination by the health carrier or within three (3) business days after the date of receipt of the determination by the commissioner, the health carrier shall notify the aggrieved person in writing of the request's eligibility and acceptance for external review.

(2) The health carrier shall include in the notice provided to the aggrieved person, a statement that additional information may be submitted in writing to the health carrier, within six (6) business days following the date of receipt of the notice provided pursuant to this subsection (g), that the external review organization shall consider when conducting the external review. The health carrier is not required to, but may, accept and consider additional information submitted by the aggrieved person after six (6) business days.

(3) Within one (1) business day after the receipt of the notice of the request to conduct external review, the external review organization shall:

(A) Select one (1) or more clinical reviewers, as it determines is appropriate, pursuant to subsection (o) to conduct the external review; and

(B) Based on the opinion of the clinical reviewer, or opinions if more than one (1) clinical reviewer has been selected to conduct the external review, make a decision to uphold or reverse the adverse determination or final adverse determination.

(4) In selecting clinical reviewers pursuant to subdivision (g)(3), the external review organization shall select physicians or other healthcare professionals who meet the minimum qualifications described in Section 22 and, through clinical experience in the past three (3) years, are experts in the treatment of the covered person's condition and knowledgeable about the recommended or requested healthcare service or treatment.

(5) Neither the aggrieved person nor the health carrier shall choose or control the choice of the physicians or other healthcare professionals selected to conduct the external review.

(6) In accordance with subsection (h), each clinical reviewer shall provide a written opinion to the external review organization on whether the recommended or requested healthcare service or treatment should be covered.

(7) In reaching an opinion, clinical reviewers are not bound by any decisions or conclusions reached during the health carrier's internal grievance process.

(h)(1) Within six (6) business days after the date of receipt of the notice provided pursuant to subsection (f), the health carrier shall provide to the external review organization any documents and information considered in making the adverse determination or the final adverse determination.

(2) Failure by the health carrier to provide the documents and information within the time specified in subsection (h) shall not delay the conduct of the external review.

(3) If the health carrier fails to provide the documents and information within the time specified in subsection (h), the external review organization may terminate the external review and make a decision to reverse the adverse determination or final adverse determination.

(4) The external review organization shall notify the health carrier within one (1) business day of its decision to reverse the adverse determination or final adverse determination pursuant to subdivision (h)(3). The health carrier shall notify the aggrieved person within three (3) business days of the external review organization's decision.

(i) Each clinical reviewer selected pursuant to subdivision (g)(3) shall review all of the information and documents received pursuant to subdivision (g)(2) and any other information submitted in writing by the aggrieved person.

(j)(1) Upon receipt of the information required to be forwarded pursuant to subdivision (g)(3), the health carrier may reconsider its adverse determination or final adverse determination that is the subject of the external review.

(2) Reconsideration by the health carrier of its adverse determination or final adverse determination shall not delay or terminate the external review.

(3) The external review may terminate only if the health carrier decides, upon completion of its reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the recommended or requested healthcare service or treatment that is the subject of the adverse determination or final adverse determination.

(4) Within three (3) business days after making the decision to reverse its adverse determination or final adverse determination, the health carrier shall notify the aggrieved person of its decision.

(5) The external review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to subdivision (j)(4).

(k) Within twenty (20) days after being selected in accordance with subdivision (g)(3) to conduct the external review, each clinical reviewer shall provide an opinion to the external review organization on whether the recommended or requested healthcare service or treatment should be covered. Each clinical reviewer's opinion shall be in writing and include the following information:

(1) A description of the covered person's medical condition;

(2) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested healthcare service or treatment is more likely than not to be

beneficial to the covered person than any available standard healthcare services or treatments and the adverse risks of the recommended or requested healthcare service or treatment would not be substantially increased over those available standard healthcare services or treatments;

(3) A description and analysis of any medical or scientific evidence, as that term is defined by this chapter; and

(4) Information on whether the reviewer's rationale for the opinion is based on subdivision (l)(5).

(l) In addition to the documents and information provided pursuant to subsection (g), each clinical reviewer, to the extent that the information or documents are available and the reviewer considers appropriate, shall consider the following in reaching an opinion pursuant to subsection (k):

(1) The covered person's pertinent medical records;

(2) The attending physician or healthcare professional's recommendation;

(3) Consulting reports from appropriate healthcare professionals and other documents submitted by the health carrier, aggrieved person, or the covered person's treating physician or healthcare professional;

(4) The terms of coverage under the covered person's health benefit plan with the health carrier to ensure that, but for the health carrier's determination that the recommended or requested healthcare service or treatment that is the subject of the opinion is experimental or investigational, the reviewer's opinion is not contrary to the terms of coverage under the covered person's health benefit plan with the health carrier; and

(5) Whether:

(A) The recommended or requested healthcare service or treatment has been approved by the Federal Food and Drug Administration, if applicable, for the condition; or

(B) Medical or scientific evidence-based standards that demonstrate that the expected benefits of the recommended or requested healthcare service or treatment is more likely than not to be beneficial to the covered person than any available standard healthcare service or treatment and the adverse risks of the recommended or requested healthcare service or treatment would not be substantially increased over those of available standard healthcare services or treatments.

(m)(1) Within twenty (20) days after the date it receives the opinion of each clinical reviewer, the external review organization shall make a decision and provide written notice of the decision to the health carrier. The health carrier shall notify the aggrieved person, within three (3) business days of the external review organization decision.

(2) If a majority of the clinical reviewers recommend that the recommended or requested healthcare service or treatment should be covered, the external review organization shall render a decision to reverse the health carrier's adverse determination or final adverse determination.

(3) If a majority of the clinical reviewers recommend that the recommended or requested healthcare service or treatment should not be covered, the external review organization shall render a decision to uphold the health carrier's adverse determination or final adverse determination.

(4) If the clinical reviewers are evenly split as to whether the recommended or requested healthcare service or treatment should be covered, then the external review organization shall obtain the opinion of an additional clinical reviewer in order for the external review organization to render a decision based on the opinions of a majority of the clinical reviewers; provided, that:

(A) The additional clinical reviewer selected under this subdivision (m) shall use the same information to reach an opinion as the clinical reviewers who have already submitted their opinions pursuant to subsection (i).

(B) The selection of the additional clinical reviewer under this subdivision (m) shall not extend the time within which the external review organization is required to render a decision based on the opinions of the clinical reviewers selected under subsection (g).

(5) The external review organization shall include in the notice provided pursuant to this subsection (m):

(A) A general description of the reason for the request for external review;

(B) The written opinion of each clinical reviewer, including the recommendation of each clinical reviewer as to whether the recommended or requested healthcare service or treatment should be covered and the rationale for the clinical reviewer's recommendation;

(C) The date that the external review organization was notified by the health carrier to conduct the external review;

(D) The date that the external review was conducted;

(E) The date of the external review organization's decision;

(F) The principal reason or reasons for the external review organization's decision; and

(G) The rationale for the external review organization's decision.

(6) Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, the health carrier shall immediately approve coverage of the recommended or requested healthcare service or treatment that was the subject of the adverse determination or final adverse determination. If the decision involved healthcare provider compensation, the health carrier shall make appropriate payment to the healthcare provider within ten (10) business days of the receipt of a notice of the decision from the external review organization.

(n)(1) Within six (6) months after the date of a notice of an adverse determination that involves a denial of coverage based upon the determination that the healthcare service or treatment recommended or requested is experimental or investigational, an aggrieved person may file a request for an expedited external review of the adverse determination. The covered person's treating physician must certify, in writing, that the recommended or requested healthcare service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

(2) Upon notice of the request for expedited external review, the health carrier shall immediately determine whether the request meets the reviewability requirements of subsection (b). The health carrier shall immediately notify the aggrieved person of its eligibility determination.

(3) The notice of initial determination shall include a statement informing the aggrieved person that a health carrier's initial determination that the request for external review is ineligible for review and may be appealed to the commissioner; provided, that:

(A) The commissioner may determine that a request is eligible for external review notwithstanding a health carrier's initial determination that the request is ineligible and that it be referred to external review; and

(B) In making a determination under subdivision (n)(3)(A), the commissioner's decision shall be made in accordance with the terms of the covered person's health benefit plan and shall be subject to all applicable provisions of this chapter.

(4) Upon making a determination that a request is eligible for expedited external review, the health carrier shall immediately notify the aggrieved person in writing that the request is eligible for external review.

(5) At the same time, the health carrier shall immediately notify the external review organization and provide or transmit all necessary documents and information considered when making the adverse determination or final adverse determination electronically or by telephone, facsimile or any other expeditious method available.

(6) Within one (1) business day after the receipt of the notice to conduct an expedited external review, the external review organization shall:

(A) Select one (1) or more clinical reviewers, as it deems appropriate to conduct the expedited external review;

(B) Based on the decision of the clinical reviewer or reviewers render a decision to uphold or reverse the decision of the adverse determination;

(C) Require each clinical reviewer to provide an opinion, orally or in writing, to the external review organization as expeditiously as the covered person's medical condition or circumstances requires, but in no event more than five (5) days after being selected; and

(D) If the opinion was not in writing, within forty-eight (48) hours following the date that the opinion was provided, require the clinical reviewer to provide written confirmation of the opinion to the external review organization and include the information required in subsections (k) and (l).

(7) Upon receipt of a notice of a decision reversing the adverse determination, the health carrier shall immediately approve the coverage of the recommended or requested healthcare service or treatment that was the subject of the adverse determination.

(o) The health carrier, regardless of URAC accreditation, shall have a contract with at least two (2) or more external review entities and may give the aggrieved person the opportunity to select, from among the external review organizations that the health carrier has contracts with the external review organization to conduct the review.

SECTION 20. (a) An external review decision is binding on the health carrier except to the extent that the health carrier has other remedies available under applicable federal or state law.

(b) An external review decision is binding on the covered person except to the extent that the covered person has other remedies available under applicable federal or state law.

(c) An external review decision is binding on the healthcare provider except to the extent that the healthcare provider has other remedies available under applicable federal or state law.

(d) A aggrieved person, may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which the covered person has already received an external review decision pursuant to this chapter.

SECTION 21. (a) The commissioner shall approve external review organizations eligible to conduct external reviews under this chapter.

(b) In order to be eligible for approval by the commissioner to conduct external reviews under this chapter, an external review organization:

(1) Except as otherwise provided in this section, shall be accredited by a nationally recognized private accrediting entity that the commissioner has determined has external review organization accreditation standards that are equivalent to or exceed the minimum qualifications for external review organizations established under Section 22; and

(2) Shall submit an application for approval in accordance with subsection (d).

(c) The commissioner shall develop an application form for initially approving and for reapproving external review organizations to conduct external reviews.

(d) Any external review organization wishing to be approved to conduct external reviews under this chapter shall submit the application form and include with the form all documentation and information necessary for the commissioner to determine if the external review organization satisfies the minimum qualifications established under Section 22.

(e) Subject to subsection (b), an external review organization is eligible for approval under this section only if it is accredited by a nationally recognized private accrediting entity that the commissioner has determined has external review organization accreditation standards that are equivalent to or exceed the minimum qualifications for external review organizations under Section 22.

(f) The commissioner may approve external review organizations that are not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing external review organization accreditation.

(g) The commissioner may charge an application fee that external review organizations shall submit to the commissioner with an application for approval and reapproval.

(h) An approval is effective for two (2) years, unless the commissioner determines before its expiration that the external review organization is not satisfying the minimum qualifications established under Section 22. Whenever the commissioner determines that an external review organization has lost its accreditation or no longer satisfies the minimum requirements established under Section 22, the commissioner shall terminate the approval of the external review organization and remove the external review organization from the list of external review organizations approved to conduct external reviews under this chapter that is maintained by the commissioner pursuant to subsection (i).

(i) The commissioner shall maintain and periodically update a list of approved external review organizations.

(j) The commissioner may promulgate rules and regulations to carry out the provisions of this section.

SECTION 22. (a) To be approved under Section 21 to conduct external reviews, an external review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in this chapter that include, at a minimum:

(1) A quality assurance mechanism in place that:

(A) Ensures that external reviews are conducted within the specified timeframes and required notices are provided in a timely manner;

(B) Ensures the selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the external review organization; suitable matching of reviewers to specific cases; and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this objective;

(C) Ensures the confidentiality of medical and treatment records and clinical review criteria; and

(D) Ensures that any person employed by or under contract with the external review organization adheres to the requirements of this chapter;

(2) A toll-free telephone service to receive information on a twenty-four (24) hour a day, seven (7) day a week basis related to external reviews that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during hours outside of normal business hours; and

(3) Agree to maintain and provide to the commissioner the information set out in Section 26.

(b) All clinical reviewers aggrieved by an external review organization to conduct external reviews shall be physicians or other appropriate healthcare providers who meet the following minimum qualifications:

(1) Be an expert in the treatment of the covered person's medical condition that is the subject of the external review;

(2) Be knowledgeable about the recommended healthcare service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person;

(3) Hold a non-restricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

(4) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical reviewer's physical, mental or professional competence or moral character.

(c) In addition to the requirements set forth in subsection (a), an external review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a health benefit plan, a national, state or local trade association of health benefit plans, or a national, state or local trade association of healthcare providers.

(d) In addition to the requirements set forth in subsections (a), (b) and (c), to be approved pursuant to Section 23 to conduct an external review of a specified case, neither the external review organization selected to conduct the external review nor any clinical reviewer assigned by the external organization to conduct the external review may have a material professional, familial or financial conflict of interest with any of the following:

(1) The health carrier that is the subject of the external review;

(2) The covered person whose treatment is the subject of the external review or the covered person's authorized representative;

(3) Any officer, director or management employee of the health carrier that is the subject of the external review;

(4) The healthcare provider, the healthcare provider's medical group or independent practice association recommending the healthcare service or treatment that is the subject of the external review;

(5) The facility at which the recommended healthcare service or treatment would be provided; or

(6) The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the external review.

(e) In determining whether an external review organization or a clinical reviewer of the external review organization has a material professional, familial or financial conflict of interest for purposes of subsection (d), the commissioner shall take into consideration situations where the external review organization conducting an external review of a specified case or a clinical reviewer to be assigned by the external review organization to conduct an external review of a specified case may have an apparent professional, familial or financial relationship or connection with a person described in subsection (d), but that the characteristics of that relationship or connection are such that they are not a material professional, familial or financial conflict of interest that results in the disapproval of the independent review organization or the clinical reviewer from conducting the external review.

(f) An external review organization that is accredited by a nationally recognized private accrediting entity that has external review accreditation standards that the commissioner has determined are equivalent to or exceed the minimum qualifications of this section shall be presumed in compliance with this section to be eligible for approval under Section 23.

(g) The commissioner shall initially review and periodically review the external review organization accreditation standards of a nationally recognized private accrediting entity to determine whether the entity's standards are, and continue to be,

equivalent to or exceed the minimum qualifications established under this section. The commissioner may accept a review conducted by the NAIC for the purpose of the determination under this subsection (g).

(h) Upon request, a nationally recognized private accrediting entity shall make its current external review organization accreditation standards available to the commissioner or the NAIC in order for the commissioner to determine if the entity's standards are equivalent to or exceed the minimum qualifications established under this section. The commissioner may exclude any private accrediting entity that is not reviewed by the NAIC.

(i) An external review organization shall be unbiased. An external review organization shall establish and maintain written procedures to ensure that it is and remains unbiased in addition to any other procedures required under this section.

SECTION 23. No external review organization or clinical reviewer working on behalf of an external review organization or an employee, agent or contractor of an external review organization shall be liable in damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to this chapter, unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.

SECTION 24. (a) An external review organization conducting an external review pursuant to this chapter shall maintain written records in the aggregate by state and by health carrier on all requests for external review for which it conducted an external review during a calendar year and, upon request, submit a report to the commissioner, as required under subdivision (a)(2).

(1) Each external review organization required to maintain written records on all requests for external review for which it conducted an external review shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

(2) The report shall include in the aggregate by state, and for each health carrier:

(A) The total number of requests for external review;

(B) The number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse determination or final adverse determination and the number resolved reversing the adverse determination or final adverse determination;

(C) The average length of time for resolution;

(D) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the commissioner;

(E) The number of external reviews pursuant to Section 17 that were terminated as the result of a reversal by the health carrier of its adverse determination or final adverse determination after the receipt of additional information from the covered person or the covered person's authorized representative; and

(F) Any other information that the commissioner may request or require.

(3) The external review organization shall retain the written records required pursuant to this subsection (a) for at least three (3) years.

(b) Each health carrier shall maintain written records in the aggregate, by state and for each type of health benefit plan offered by the health carrier on all requests for external review that the health carrier receives notice of from the commissioner pursuant to this chapter.

(1) Each health carrier required to maintain written records on all requests for external review pursuant to this subsection (b) shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

(2) The report shall include in the aggregate, by state, and by type of health benefit plan:

(A) The total number of requests for external review;

(B) From the total number of requests for external review reported under subdivision (b)(2)(A), the number of requests determined eligible for a full external review; and

(C) Any other information that the commissioner may request or require.

(3) The health carrier shall retain the written records required pursuant to this subsection (b) for at least three (3) years.

SECTION 25. The health carrier against which a request for a standard external review or an expedited external review is filed shall pay the cost of the external review organization for conducting the external review.

SECTION 26. (a) Each health carrier shall include a description of the external review procedures in or attached to the membership booklet, provider manual, and health carrier's Web site. The health carrier may include a description of the external review procedures in the policy, certificate, outline of coverage, or other evidence of coverage provided to covered persons and providers.

(b) The disclosure required by subsection (a) shall be in a format prescribed by the commissioner.

(c) The description required under subsection (a) shall include a statement that informs the covered person or the covered person's authorized representative of the right of the covered person or the covered person's authorized representative to file a request for an external review of an adverse determination or final adverse determination with the carrier. The statement may explain that an external review is available when the adverse determination or final adverse determination involves an issue of medical necessity, appropriateness, healthcare setting, level of care or effectiveness. The statement shall include the telephone number and address of the commissioner.

(d) In addition to subsection (b), the statement shall inform the covered person that, when filing a request for an external review, the covered person will be required to authorize the release of any medical records of the covered person that may be required to be reviewed for the purpose of reaching a decision on the external review.

SECTION 27. Tennessee Code Annotated, Section 56-32-110, is amended by deleting the section in its entirety.

SECTION 28. Tennessee Code Annotated, Section 56-32-127, is amended by deleting the section in its entirety.

SECTION 29. Tennessee Code Annotated, Section 56-32-103(b)(11), is amended by deleting the subdivision in its entirety and by substituting instead:

(b)(11) A description of the complaint procedure to be utilized pursuant to the Tennessee Health Carrier Grievance and External Review Procedure Act, compiled in Title 56; and

SECTION 30. If any provision of this act, or the application of any provision to any person or circumstance shall be held invalid, the remainder of the act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

SECTION 31. For purposes of promulgating rules and regulations, this act shall take effect upon becoming a law, the public welfare requiring it, for all other purposes, this act shall take effect January 1, 2011.

On motion, Amendment No. 1 was adopted.

Senator Johnson moved that **Senate Bill No. 3806**, as amended, be placed on the Calendar for Monday, March 29, 2010, which motion prevailed.

MOTION

Senator Burchett moved that Rule 37 be suspended for the immediate consideration of **Senate Joint Resolution No. 895**, out of order, which motion prevailed.

RESOLUTION LYING OVER

Senate Joint Resolution No. 895 -- Memorials, Recognition -- Fiona Hyslop, Scottish Minister for Culture and External Affairs.

On motion of Senator Burchett, the rules were suspended for the immediate consideration of the resolution.

On motion, **Senate Joint Resolution No. 895** was adopted.

CALENDAR

Senate Bill No. 3814 -- Business Organizations -- As introduced, authorizes anyone to apply to the secretary of state to furnish a certificate of existence for a domestic LLC, LLP, or LP or a certificate of authorization for a foreign LLC, LLP, or LP. Amends TCA Title 48 and Title 61.

On motion, Senate Bill No. 3814 was made to conform with **House Bill No. 3644**.

On motion, House Bill No. 3644, on same subject, was substituted for Senate Bill No. 3814.

On motion of Senator Johnson, Amendment No. 1 was withdrawn.

Thereupon, **House Bill No. 3644** passed its third and final consideration by the following vote:

Ayes 31
Noes 0

Senators voting aye were: Barnes, Berke, Black, Bunch, Burchett, Burks, Crowe, Faulk, Finney, Ford, Gresham, Harper, Haynes, Henry, Jackson, Johnson, Kelsey, Ketron, Kyle, Marrero, McNally, Norris, Overbey, Southerland, Stewart, Tate, Tracy, Watson, Woodson, Yager and Mr. Speaker Ramsey--31.

A motion to reconsider was tabled.

Senate Bill No. 3815 -- Business Organizations -- As introduced, creates an additional exception to the general rule that the name of a corporation or limited partnership (LP) must be distinguishable upon the records of the secretary of state from the name of another business organization authorized to do business in this state. Amends TCA Title 48 and Title 61.

On motion, Senate Bill No. 3815 was made to conform with **House Bill No. 3645**.

On motion, House Bill No. 3645, on same subject, was substituted for Senate Bill No. 3815.

On motion of Senator Johnson, Amendment No. 1 was withdrawn.

On motion of Senator Johnson, Amendment No. 2 was withdrawn.

Thereupon, **House Bill No. 3645** passed its third and final consideration by the following vote:

Ayes 31
Noes 0

Senators voting aye were: Barnes, Berke, Black, Bunch, Burchett, Burks, Crowe, Faulk, Finney, Ford, Gresham, Harper, Haynes, Henry, Herron, Jackson, Johnson, Kelsey, Ketron, Kyle, Marrero, McNally, Norris, Overbey, Southerland, Tate, Tracy, Watson, Woodson, Yager and Mr. Speaker Ramsey--31.

A motion to reconsider was tabled.

Senate Bill No. 2813 -- Courts, Circuit -- As introduced, authorizes circuit court judges in Davidson County having domestic or probate jurisdiction to appoint one or more persons to act as magistrates. Amends TCA Section 17-2-123.

Senator Jackson moved to amend as follows:

AMENDMENT NO. 1

AMEND by deleting all language after the enacting clause and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 17-2-123, is amended by deleting the section in its entirety and by substituting instead the following:

(a)(1) Notwithstanding any other law to the contrary, in any county having a metropolitan form of government and having a population of more than five hundred thousand (500,000), according to the 1990 federal census or any subsequent federal census, the circuit court judges of such county may appoint a full-time master to serve as a judicial officer in the absence of any such judges.

(2) A master appointed pursuant to subsection (1) shall be an attorney licensed to practice law by this state and in good standing with the board of professional responsibility.

(3) The compensation for a master appointed pursuant to this section shall be fixed by the presiding judge of the judicial district and shall be paid from any fund appropriated for such purpose by the county governing body.

(4) The master shall have all the powers specified in § 17-2-118 and the powers granted to masters by Tenn. R. Civ. P. 53.

(b)(1) Notwithstanding any other law to the contrary, in any county having a metropolitan form of government and a population of more than five hundred thousand (500,000), according to the 1990 federal census or any subsequent federal census, the circuit courts having domestic or probate jurisdiction may appoint one (1) or more suitable persons to act as magistrates at the pleasure of the judge. A magistrate shall be a member of the bar in good standing and shall hold office at the pleasure of the judge. The compensation of a magistrate shall be fixed by the judge with approval of the county legislative body or the pertinent governing body, and paid from public funds.

(2) The judge or judges for whom the magistrate serves may direct that any case or class of cases shall be heard in the first instance by the magistrate in all cases wherein the respective circuit court has jurisdiction in the manner provided for the hearing of cases by the court.

(3) A magistrate has the same authority as the judge to issue any and all process. The magistrate in the conduct of the proceedings has the powers of a trial judge.

(4) Upon the conclusion of the hearing in each case, the magistrate shall transmit to the judge all papers relating to the case, together with the magistrate's findings and recommendations in writing.

(5) Any party may, within five (5) days thereafter, excluding nonjudicial days, file a request with the court for hearing by the appropriate circuit court judge. The judge may, on the judge's own motion, order a rehearing of any matter heard before a magistrate, and shall allow a hearing if a request for such hearing is filed as herein prescribed. Unless the judge orders otherwise, the order of the magistrate shall be the decree of the court pending a rehearing.

(6) Any appeal from the magistrate to the judge from a final order shall be tried de novo by the judge.

(7) In case no hearing of a final order before the judge is requested, or when the right to a hearing is waived, the findings and recommendations of the magistrate become the decree of the court when confirmed by an order of the judge. The final order of the court is, in any event, proof of such confirmation, and also of the fact that the matter was duly referred to the magistrate.

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it.

On motion, Amendment No. 1 was adopted.

Senator Jackson moved to amend as follows:

AMENDMENT NO. 2

AMEND by deleting the word "magistrate" wherever it appears and substituting instead the word "master".

AND FURTHER AMEND by deleting the word "magistrates" wherever it appears and substituting instead the word "masters".

AND FURTHER AMEND by deleting the word "magistrate's" wherever it appears and substituting instead the word "master's".

AND FURTHER AMEND by deleting the language "having domestic or probate jurisdiction" from subdivision (b)(1) in the amendatory language of Section 1 of the bill and by substituting instead the language "exercising domestic or probate jurisdiction".

On motion, Amendment No. 2 was adopted.

Thereupon, **Senate Bill No. 2813**, as amended, passed its third and final consideration by the following vote:

Ayes 31
Noes 0

Senators voting aye were: Barnes, Berke, Black, Bunch, Burchett, Burks, Crowe, Faulk, Finney, Ford, Gresham, Harper, Haynes, Henry, Herron, Jackson, Johnson, Kelsey, Ketron, Kyle, Marrero, McNally, Norris, Overbey, Southerland, Stewart, Tate, Watson, Woodson, Yager and Mr. Speaker Ramsey--31.

A motion to reconsider was tabled.

Senate Bill No. 3726 -- Remedies and Special Proceedings -- As introduced, allows general sessions judge to postpone trial for forcible detainer cases longer than 15 days upon agreement of the parties. Amends TCA Section 29-18-118.

Senator Finney declared Rule 13 on **Senate Bill No. 3726**.

Senator Jackson moved to amend as follows:

AMENDMENT NO. 1

AMEND by deleting all language after the enacting clause and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Section 29-18-118, is amended by deleting the section in its entirety and substituting instead the following:

> The general sessions judge may, at the request of either party, and on good reason being assigned, postpone the trial to any time not exceeding fifteen (15) days. The postponement shall not be for a longer period of time unless agreed upon by the parties, no civil court is being conducted, or upon request of the plaintiff, the party making the application for postponement paying the costs.

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it.

On motion, Amendment No. 1 was adopted.

Thereupon, **Senate Bill No. 3726**, as amended, passed its third and final consideration by the following vote:

Ayes 29
Noes 0

Senators voting aye were: Barnes, Black, Burchett, Burks, Crowe, Faulk, Finney, Ford, Gresham, Harper, Haynes, Henry, Herron, Jackson, Johnson, Kelsey, Ketron, Kyle, Marrero, McNally, Norris, Overbey, Southerland, Stewart, Tate, Watson, Woodson, Yager and Mr. Speaker Ramsey--29.

A motion to reconsider was tabled.

Senate Bill No. 3731 -- Workers' Compensation -- As introduced, establishes a procedure for handling disputes involving future medicals in a workers' compensation case after judgment or settlement. Amends TCA Title 50, Chapter 6.

Senator Berke declared Rule 13 on **Senate Bill No. 3731**.

Senator Overbey declared Rule 13 on **Senate Bill No. 3731**.

Senator Johnson moved to amend as follows:

AMENDMENT NO. 1

AMEND by adding the following language as a new subdivision at the end of the amendatory language in Section 1 of the printed bill:

(E) Under the authority granted to a court by § 50-6-204(b)(2) and § 50-6-226 when considering a request for enforcement of this subdivision (g)(2), a court may award attorney fees and other reasonable costs as set by the court.

On motion, Amendment No. 1 was adopted.

Thereupon, **Senate Bill No. 3731**, as amended, passed its third and final consideration by the following vote:

Ayes 31
Noes 0

Senators voting aye were: Barnes, Berke, Black, Bunch, Burchett, Burks, Crowe, Faulk, Finney, Ford, Gresham, Harper, Haynes, Henry, Herron, Jackson, Johnson, Kelsey, Ketron, Kyle, Marrero, McNally, Norris, Overbey, Southerland, Stewart, Tate, Watson, Woodson, Yager and Mr. Speaker Ramsey--31.

A motion to reconsider was tabled.

Senate Bill No. 3339 -- Alcoholic Beverages -- As introduced, authorizes sales of alcoholic beverages on charter boat departing certain premier type tourist resort in Jefferson County; revises geographic requirement for a facility to qualify as premier type tourist resort in Jefferson County. Amends TCA Title 57, Chapter 4, Part 1.

On motion of Senator Henry, Amendment No. 1 was withdrawn.

Thereupon, **Senate Bill No. 3339** passed its third and final consideration by the following vote:

Ayes 21
Noes 5

Senators voting aye were: Barnes, Berke, Burchett, Crowe, Finney, Ford, Harper, Haynes, Henry, Jackson, Johnson, Ketron, Kyle, Marrero, McNally, Norris, Overbey, Stewart, Tate, Woodson and Mr. Speaker Ramsey--21.

Senators voting no were: Black, Bunch, Burks, Herron and Southerland--5.

A motion to reconsider was tabled.

Senate Bill No. 3684 -- Taxes, Real Property -- As introduced, removes the exceptions to the requirement that when property has been assessed for property taxation in a county for at least five years, the state board of equalization may not rule that the property is located in a different county; and authorizes the board to redress double assessment in these circumstances. Amends TCA Section 5-2-115.

On motion, Senate Bill No. 3684 was made to conform with **House Bill No. 3609**.

On motion, House Bill No. 3609, on same subject, was substituted for Senate Bill No. 3684.

House Bill No. 3609 passed its third and final consideration by the following vote:

Ayes 30
Noes 0

Senators voting aye were: Barnes, Berke, Black, Burchett, Burks, Crowe, Faulk, Finney, Ford, Gresham, Harper, Haynes, Henry, Herron, Jackson, Johnson, Kelsey, Ketron, Kyle, Marrero, McNally, Norris, Overbey, Southerland, Stewart, Tate, Watson, Woodson, Yager and Mr. Speaker Ramsey--30.

A motion to reconsider was tabled.

Senator Kelsey moved that **Senate Joint Resolution No. 763**, as amended, be placed on the Calendar for Monday, March 29, 2010, which motion prevailed.

MESSAGE CALENDAR

SENATE BILL ON HOUSE AMENDMENT

Senate Bill No. 3522 -- Trusts -- As introduced, updates the trust laws. Amends TCA Title 35; Title 45, Chapter 2 and Title 66.

Senator Ford declared Rule 13 on **Senate Bill No. 3522**.

HOUSE AMENDMENT NO. 3

AMEND by deleting Section 22 and Section 23 in their entirety, by substituting instead the following new sections and by redesignating existing sections accordingly:

SECTION 22. Tennessee Code Annotated, Section 35-3-113, is amended by deleting subsection (c) in its entirety.

SECTION 23. Tennessee Code Annotated, Section 45-2-1008, is amended by deleting from subsection (a) the language ", that the transferor and transferee banks are related institutions, as that term is defined in subsection (g), and".

SECTION 24. The Tennessee Code Commission is requested to publish in the Tennessee Code Annotated the revisions to the official comments that are filed with the executive secretary of the Tennessee Code Commission within 30 days of July 1, 2010, by members of the Estate and Probate Section of the Tennessee Bar Association, the Probate Study Committee of the Tennessee Bar Association and the Trust Committee of the Tennessee Bankers Association.

AND FURTHER AMEND by deleting Section 6 in its entirety and by substituting instead the following:

SECTION 6. Tennessee Code Annotated, Section 35-15-505(a)(2), is amended by deleting the introductory phrase: "Except as provided in chapter 16 of this title regarding investment services trusts", and replacing it with the introductory phrase: "Except as provided in Chapter 16 of this title regarding investment services trusts and subdivision (a)(3) regarding an irrevocable special needs trust".

Tennessee Code Annotated, Section 35-15-505(a), is further amended by renumbering subdivision (a)(3) as subdivision (a)(5), and adding new subdivisions (a)(3) and (a)(4) as follows:

(a)(3) For the purposes of this section "irrevocable special needs trust" means an irrevocable trust established for the benefit of one or more disabled persons, which includes, but is not limited to, any individual who is disabled pursuant to 42 U.S.C. § 1382c(a), as well as any individual who is disabled pursuant to any similar federal, state or other jurisdictional law or regulation, or has a condition that is substantially equivalent to one that qualifies them to be so disabled in accordance with any of the above even if not officially found to be so disabled by a governmental body if one of the purposes of the trust, expressed in the trust instrument or implied from the trust instrument, is to allow the disabled person to qualify or continue to qualify for public, charitable or private benefits that might otherwise be available to the disabled person. The existence of one or more nondisabled remainder beneficiaries of the trust shall not disqualify it as an irrevocable special needs trust for the purposes of this section.

(4) No creditor or assignee of the settlor of an irrevocable special needs trust, as defined in subdivision (a)(3), may reach or compel distributions from such special needs trust, to or for the benefit of the settlor of such special needs trust, or otherwise, regardless of whether or not such irrevocable special needs trust complies with the provisions of, and irrespective of the requirements of, Chapter 16 of this title.

AND FURTHER AMEND by deleting from Section 8 subdivision (g)(6) in its entirety and by substituting instead the following:

(6) "Investment" shall mean any security as defined in § 2(a)(1) of the Securities Act of 1933, any contract of sale of a commodity for future delivery within the meaning of § 2(i) of the Commodity Exchange Act, or any other asset permitted for fiduciary accounts pursuant to the terms of Chapter 14 of this title or by the terms of the governing instrument, including by way of illustration and not limitation: shares or interests in a public or private investment fund, which shall include, but not be limited to, a public or private investment fund organized as a limited partnership, limited liability company, statutory or common law business trust, real

estate investment trust, joint venture or other general or limited partnership; or an open-end or closed-end management type investment company or investment trust registered under the Investment Company Act of 1940.

AND FURTHER AMEND by deleting from Section 8, subsection (h) in its entirety and by substituting instead the following:

(h) A fiduciary seeking compensation pursuant to subsection (f) shall, as is applicable relative to the fiduciary's particular appointment, disclose either: to those persons entitled to be kept informed about the administration of a trust under § 35-15-813(a)(1), subject to the provisions of subsections (d) and (e) of § 35-15-813; to each principal in an agency relationship; or to all current recipients of statements of any other fiduciary account not described above; all fees or commissions paid or to be paid by the account, or received or to be received by an affiliate arising from such affiliated investment or delegation to an affiliate or associated agent. The disclosure required under this subsection may be given either in a copy of the prospectus or any other disclosure document prepared for the affiliated investment under federal or state securities laws or in a written summary that includes all fees or commissions received or to be received by the fiduciary or any affiliate of the fiduciary and an explanation of the manner in which such fees or commissions are calculated, either as a percentage of the assets invested or by some other method. Such disclosure shall be made at least annually unless there has been no increase in the rate at which such fees or commissions are calculated since the most recent disclosure. Notwithstanding this subsection (h), no such disclosure is required if the governing instrument or a court order expressly authorizes the fiduciary to invest the fiduciary account in affiliated investments or to perform the delegation to an affiliate or associated agent.

Senator Overbey moved that the Senate concur in House Amendment No. 3 to **Senate Bill No. 3522**, which motion prevailed by the following vote:

Ayes 31
Noes 0

Senators voting aye were: Barnes, Berke, Black, Bunch, Burchett, Burks, Crowe, Faulk, Finney, Ford, Gresham, Harper, Haynes, Henry, Herron, Jackson, Johnson, Kelsey, Ketron, Kyle, Marrero, McNally, Norris, Overbey, Southerland, Stewart, Tate, Watson, Woodson, Yager and Mr. Speaker Ramsey--31.

A motion to reconsider was tabled.

MOTION

Senator Norris moved that the Proposed Schedule, as amended, for the week of March 29, 2010, be adopted and made the action of the Senate, which motion prevailed.

TENNESSEE STATE SENATE
106th GENERAL ASSEMBLY

PROPOSED SCHEDULE
FOR THE WEEK OF MARCH 29, 2010

MONDAY – March 29

3:30 p.m.	–	5:00 p.m.	Commerce, Labor & Agriculture Committee

5:00 p.m.			Session – Senate Chamber

TUESDAY – March 30

8:30 a.m.	–	10:30 a.m.	Finance, Ways & Means Committee (Tax Sub will meet immediately following)
10:30 a.m.	–	12:00 p.m.	State & Local Government Committee
12:00 p.m.	–	12:30 p.m.	Lunch
12:30 p.m.	–	3:00 p.m.	Commerce, Labor & Agriculture Committee
3:00 p.m.	–	5:00 p.m.	Judiciary Committee

WEDNESDAY – March 31

8:00 a.m.	–	8:30 a.m.	Budget Subcommittee of Finance, Ways & Means Committee
8:30 a.m.			Session – Senate Chamber
10:00 a.m.	–	12:00 noon	State & Local Government Committee
12:00 noon	–	1:00 p.m.	Lunch
1:00 p.m.	–	2:30 p.m.	Government Operations Committee
2:30 p.m.	–	5:00 p.m.	Education Committee

THURSDAY – April 1

9:00 a.m.			Session – Senate Chamber

NOTE: Joint Government Operations Committee rules review, Monday, March 29, 2010, at 1:30 p.m., Room 30 LP.

Pre-Commerce meeting, Tuesday, March 30, 2010, at 7:30 a.m., Room 12 LP.

The following committees will not meet this week:
Environment, Conservation & Tourism Committee
General Welfare, Health & Human Resources Committee
Transportation Committee

MOTION

On motion of Senators Overbey and Tracy, their names were added as sponsors of **Senate Joint Resolution No. 879**.

On motion of Senator Jackson, his name was added as sponsor of **House Joint Resolution No. 908**.

On motion of Senators Jackson and Tracy, their names were added as sponsors of **House Joint Resolution No. 909**.

On motion of Senator Faulk, his name was added as sponsor of **House Joint Resolution No. 910**.

On motion of Senators Crowe, Berke, Overbey, Marrero, Burks, Faulk and Black, their names were added as sponsors of **Senate Bill No. 2531**.

On motion of Senators Marrero and Burks, their names were added as sponsors of **Senate Bill No. 3859**.

On motion of Senators Crowe and Marrero, their names were added as sponsors of **Senate Bill No. 3824**.

On motion of Senators Crowe, Berke, Overbey, Ketron and Tracy, their names were added as sponsors of **Senate Bill No. 2782**.

On motion of Senator Crowe, his name was added as sponsor of **Senate Bill No. 3140**.

On motion of Senators Marrero, Burks and Ford, their names were added as sponsors of **Senate Bill No. 3320**.

On motion of Senator Marrero, her name was added as sponsor of **Senate Bill No. 3276**.

On motion of Senator Burks, her name was added as sponsor of **Senate Bill No. 2497**.

On motion of Senator Tracy, his name was added as sponsor of **Senate Bill No. 2666**.

On motion of Senators Burks, Faulk and Ford, their names were added as sponsors of **Senate Bill No. 2729**.

On motion of Senators Faulk and Crowe, their names were added as sponsors of **Senate Bill No. 2780**.

On motion of Senators Ketron and Black, their names were added as sponsors of **Senate Bill No. 3164**.

On motion of Senator Ford, her name was added as sponsor of **Senate Bill No. 3277; and Senate Joint Resolution No. 878**.

On motion of Senators Overbey, Ketron, Burks, Faulk, Barnes and Berke, their names were added as sponsors of **Senate Bill No. 3416**.

On motion of Senator Berke, his name was added as sponsor of **Senate Bill No. 3806**.

On motion of Senators Woodson, Henry, Barnes, Berke, Black, Bunch, Burks, Crowe, Faulk, Finney, Ford, Gresham, Harper, Haynes, Herron, Jackson, Johnson, Kelsey, Ketron, Kyle, Marrero,

McNally, Norris, Overbey, Southerland, Stewart, Tate, Tracy, Watson, Yager and Mr. Speaker Ramsey, their names were added as sponsors of **Senate Joint Resolution No. 895**.

On motion of Senator Ketron, his name was added as sponsor of **Senate Bills Nos. 3110 and 3731; and House Joint Resolution No. 907**.

On motion of Senator Bunch, his name was added as sponsor of **Senate Bill No. 3181**.

On motion of Senator Kyle, his name was added as sponsor of **Senate Bill No. 3049**.

On motion of Senators Yager and Tate, their names were added as sponsors of **Senate Bill No. 3528**.

On motion of Senators Black, Tracy, Overbey and Ketron, their names were added as sponsors of **Senate Bill No. 3060**.

On motion of Senator Black, her name was added as sponsor of **Senate Bill No. 3437**.

ENGROSSED BILLS
March 25, 2010

MR. SPEAKER: Your Chief Engrossing Clerk begs leave to report that we have carefully examined Senate Bills Nos. 2497, 2531, 2666, 2782, 2813, 2943, 3140, 3164, 3276, 3277, 3436, 3726, 3731, 3824 and 3859; and Senate Joint Resolutions Nos. 877, 878 and 879; and find same correctly engrossed and ready for transmission to the House.

M. SCOTT SLOAN,
Chief Engrossing Clerk.

ENGROSSED BILLS
March 25, 2010

MR. SPEAKER: Your Chief Engrossing Clerk begs leave to report that we have carefully examined Senate Bills Nos. 2630 and 3339; and Senate Joint Resolution No. 895; and find same correctly engrossed and ready for transmission to the House.

M. SCOTT SLOAN,
Chief Engrossing Clerk.

MESSAGE FROM THE HOUSE
March 25, 2010

MR. SPEAKER: I am directed to transmit to the Senate, House Bills Nos. 2510, 2931, 3300, 3364, 3459, 3517, 3522, 3586, 3608, 3652 and 3957; passed by the House.

BURNEY T. DURHAM,
Chief Clerk.

MESSAGE FROM THE HOUSE
March 25, 2010

MR. SPEAKER: I am directed to transmit to the Senate, House Joint Resolutions Nos. 906, 928, 929, 931, 933, 934, 935, 936, 937, 938, 939 and 940; adopted, for the Senate's action.

BURNEY T. DURHAM,
Chief Clerk.

MESSAGE FROM THE HOUSE
March 25, 2010

MR. SPEAKER: I am directed to return to the Senate, Senate Bills Nos. 1553 and 3579, substituted for House Bills on same subjects and passed by the House.

BURNEY T. DURHAM,
Chief Clerk.

MESSAGE FROM THE HOUSE
March 25, 2010

MR. SPEAKER: I am directed to return to the Senate, Senate Bills Nos. 2607 and 3359, substituted for House Bills on same subjects and passed by the House.

BURNEY T. DURHAM,
Chief Clerk.

MESSAGE FROM THE HOUSE
March 25, 2010

MR. SPEAKER: I am directed to return to the Senate, Senate Joint Resolutions Nos. 787, 866, 867, 868 and 870; concurred in by the House.

BURNEY T. DURHAM,
Chief Clerk.

MESSAGE FROM THE HOUSE
March 25, 2010

MR. SPEAKER: I am directed to return to the Senate, Senate Joint Resolutions Nos. 850 and 895, concurred in by the House.

BURNEY T. DURHAM,
Chief Clerk.

MESSAGE FROM THE HOUSE
March 26, 2010

MR. SPEAKER: I am directed to return to the Senate, Senate Joint Resolution No. 30. It was read three separate times on three separate days, and concurred in by over a two-thirds

majority vote of the House of Representatives of the One Hundred Sixth General Assembly of the State of Tennessee, pursuant to Article XI, Section 3 of the Constitution of Tennessee.

BURNEY T. DURHAM,
Chief Clerk.

ENROLLED BILLS
March 25, 2010

MR. SPEAKER: Your Chief Engrossing Clerk begs leave to report that we have carefully compared Senate Bills Nos. 1553, 2607, 3522 and 3579; and find same correctly enrolled and ready for the signatures of the Speakers.

M. SCOTT SLOAN,
Chief Engrossing Clerk.

ENROLLED BILLS
March 25, 2010

MR. SPEAKER: Your Chief Engrossing Clerk begs leave to report that we have carefully compared Senate Bill No. 3359, and find same correctly enrolled and ready for the signatures of the Speakers.

M. SCOTT SLOAN,
Chief Engrossing Clerk.

ENROLLED BILLS
March 25, 2010

MR. SPEAKER: Your Chief Engrossing Clerk begs leave to report that we have carefully compared Senate Joint Resolutions Nos. 787, 850, 866, 867, 868, 870 and 895; and find same correctly enrolled and ready for the signatures of the Speakers.

M. SCOTT SLOAN,
Chief Engrossing Clerk.

MESSAGE FROM THE HOUSE
March 25, 2010

MR. SPEAKER: I am directed to transmit to the Senate, House Bills Nos. 187, 2941, 3139, 3148, 3168, 3454, 3610, 3643, 3819, 3830 and 3836; for the signature of the Speaker.

BURNEY T. DURHAM,
Chief Clerk.

MESSAGE FROM THE HOUSE
March 25, 2010

MR. SPEAKER: I am directed to transmit to the Senate, House Joint Resolutions Nos. 907, 908, 909 and 910; for the signature of the Speaker.

BURNEY T. DURHAM,
Chief Clerk.

SIGNED
March 25, 2010

The Speaker announced that he had signed the following: Senate Joint Resolutions Nos. 787, 850, 866, 867, 868, 870 and 895.

SIGNED
March 26, 2010

The Speaker announced that he had signed the following: House Joint Resolutions Nos. 907, 908, 909 and 910.

MESSAGE FROM THE HOUSE
March 25, 2010

MR. SPEAKER: I am directed to return to the Senate, Senate Bills Nos. 2493, 2502, 2863, 2974, 3026, 3031, 3295 and 3877; signed by the Speaker.

BURNEY T. DURHAM,
Chief Clerk.

MESSAGE FROM THE HOUSE
March 25, 2010

MR. SPEAKER: I am directed to return to the Senate, Senate Joint Resolutions Nos. 787, 850, 866, 867, 868, 870 and 895; signed by the Speaker.

BURNEY T. DURHAM,
Chief Clerk.

REPORT OF CHIEF ENGROSSING CLERK
March 26, 2010

MR. SPEAKER: Your Chief Engrossing Clerk begs leave to report that we have transmitted to the Governor the following: Senate Bills Nos. 2493, 2502, 2863, 2974, 3026, 3031, 3295 and 3877; for his action.

M. SCOTT SLOAN,
Chief Engrossing Clerk.

REPORT OF CHIEF ENGROSSING CLERK
March 26, 2010

MR. SPEAKER: Your Chief Engrossing Clerk begs leave to report that we have transmitted to the Governor the following: Senate Joint Resolutions Nos. 787, 850, 866, 867, 868, 870 and 895; for his action.

M. SCOTT SLOAN,
Chief Engrossing Clerk.

MESSAGE FROM THE GOVERNOR

March 25, 2010

MR. SPEAKER: I am directed by the Governor to return herewith: Senate Bills Nos. 2425, 2427 and 2846; and Senate Joint Resolution No. 711; with his approval.

STEVEN E. ELKINS,
Counsel to the Governor.

REPORT OF COMMITTEE ON CALENDAR
CONSENT CALENDAR # 1

MR. SPEAKER: Your Committee on Calendar begs leave to report that we have met and set the following bills on the calendar for Monday, March 29, 2010: Senate Joint Resolutions Nos. 880, 881, 882, 883, 884, 885, 887 and 888; Senate Resolution No. 206; and House Joint Resolutions Nos. 911, 912, 913, 914, 915, 916, 918, 919, 920, 921, 922, 923, 924, 925, 926 and 932.

This the 25th day of March, 2010.
MIKE FAULK, Chairperson.

REPORT OF COMMITTEE ON CALENDAR
CONSENT CALENDAR # 2

MR. SPEAKER: Your Committee on Calendar begs leave to report that we have met and set the following bills on the calendar for Monday, March 29, 2010: Senate Bills Nos. 1678, 3001, 3004, 3064, 3070 and 3181; and House Joint Resolutions Nos. 746, 763, 823, 884 and 896.

This the 25th day of March, 2010.
MIKE FAULK, Chairperson.

REPORT OF COMMITTEE ON CALENDAR

MR. SPEAKER: Your Committee on Calendar begs leave to report that we have met and set the following bills on the calendar for Monday, March 29, 2010: Senate Joint Resolution No. 763; and Senate Bills Nos. 2654, 2726, 2966, 2988, 3138, 3270, 3489, 3527, 3552, 3590, 3625, 2474, 2928 and 3806.

This the 25th day of March, 2010.
MIKE FAULK, Chairperson.

REPORT OF COMMITTEE ON CALENDAR
SENATE MESSAGE CALENDAR

Pursuant to Rule 44, notice has been given on the following bill and it has been set on the Message Calendar for Monday, March 29, 2010: House Bill No. 219.

This the 25th day of March, 2010.
MIKE FAULK, Chairperson.

ADJOURNMENT

Senator Norris moved the Senate adjourn until 5:00 p.m., Monday, March 29, 2010, which motion prevailed.